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OBSTETRICAL TRANSACTIONS.

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OF THE

OBSTETRICAL SOCIETY

OF

LONDON.

VOL. VII.

FOR THE YEAR 1865.

WITH A LIST OF OFFICERS, FELLOWS, ETC.

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1862 FLEETWOOD CHURCHILL, M.D., Professor of Midwifery, King's and Queen's College of Physicians, Ireland; 15, Stephen's green north, Dublin.

1862 ALFRED H. MCCLINTOCK, M.D., late Master of the Lying-in Hospital; 21, Merrion square north, Dublin.

1862 JAMES MATTHEWS DUNCAN, M.D., A.M., Lecturer on Midwifery and Diseases of Women and Children, Surgeon's Hall; 30, Charlotte square, Edinburgh.

1862 ARCHIBALD HALL, M.D., Professor of Midwifery, University of McGill College, Montreal, Canada.

1863 JOHN PAGAN, M.D., Professor of Midwifery at the University, Glasgow.

1862 SIR JAMES Y. SIMPSON, Bart., M.D., Professor of Midwifery, University of Edinburgh, Physician-Accoucheur to the Queen in Scotland; 52, Queen street, Edinburgh.

1864 J. MARION SIMS, late Surgeon to the Women's Hospital, New York; 1, Bolton row, Piccadilly, W.

FOREIGN SUBJECTS.

1863 CARL BRAUN, M.D., Professor of Midwifery, Vienna.

Elected

1862 WALTER CHANNING, M.D., late Professor of Midwifery in the University of Cambridge, Boston, U.S.

1863 JEAN ANNE HENRI DEPAUL, M.D., Paris.

1862 BARON PAUL DUBOIS, late Professor of Clinical Midwifery in the Faculty of Medicine, Paris.

1863 F. C. FAYE, Professor of Midwifery in the University of Christiania.

1864 C. HECKER, Professor at Munich.

1863 EDUARD MARTIN, M.D., Director of the Institute for Clinical Midwifery at the University, Berlin.

1862 CHARLES D. MEIGS, M.D., late Professor of Obstetrics, &c., in the Jefferson Medical College, Philadelphia, U.S.

1864 CH. PAJOT, M.D., Professor at the Faculty of Medicine, Paris.

1862 F. W. VON SCANZONI, M.D., Professor of Midwifery, Würzburg.

1862 RUDOLF VIRCHOW, M.D., Professor of Pathological Anatomy in the University of Berlin.

ORDINARY FELLOWS.

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Elected

1864 AITKEN, WILLIAM, M.D., Professor of Midwifery, &c., in the Medical College, Madras.

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1861 ALDRIDGE, JOHN PETTY, M.D., Shirley House, Dorchester.

1859 ALLEN, GEORGE, M.D., 14A, Dean street, Soho, W.

1859 AMSDEN, GEORGE JOHN, M.D., 1, New North road, Hoxton, N.

1859 ANDREWS, JAMES, M.D., 149, Camden road, N.W.

1859 ARCHER, JOHN, F.R.C.S., Surgeon to the Birmingham Lying-in-Hospital; 9, Carpenter road, Edgbaston, Birmingham.

1861 ARMSTRONG, JOHN, M.D., Gravesend, Kent.

1860 ASHBURNER, JAMES, M.D., Surgeon in Ordinary to St. Mary's Hospital, Manchester; Broad street, Pendleton, Manchester.

1859 ASPINALL, THOMAS, Green street, Over Darwen, Lancashire.

1859 AVELING, JAMES H., M.D., Senior Medical Officer to the Sheffield Hospital for Women; 5, Howard street, Sheffield. *Council*, 1865-66. *Hon. Loc. Sec.*

1859 AYLING, WILLIAM HENRY, L.R.C.P. Ed., 103, Great Portland street, W.

1864 BAKER, BENSON, 6, Cross street, Islington, N., and 94, Lisson Grove, N.W.

1859 BAKER, JOHN WRIGHT, 102, Friar Gate, Derby.

1859 BALLARD, THOMAS, M.D., 10, Southwick place, Hyde Park, W.

1864 BALLS, WALTER, M.B., B.A. Cant., 5, Tavistock place, Tavistock square, W.C.

Elected

1865 BRUNTON, JOHN, M.D., M.A., 207, Caledonian road, Islington, N.

1863 BRYANT, THOMAS, F.R.C.S., Assistant-Surgeon to Guy's Hospital; 2, Finsbury square, E.C. *Council*, 1866.

1859 BRYANT, WALTER JOHN, F.R.C.S., L.R.C.P. Ed., 23A, Sussex square, Hyde park gardens, W. *Council*, 1859.

1864 BUCKLE, FLEETWOOD, M.D., 1, Albert square, Clapham road, S.

1861 BUNNY, JOSEPH, M.D., Hon. Surgeon to the Newbury Dispensary; Northbrook street, Newbury, Berks.

1859 BURFORD, ROBERT WILLIAM, 31, Bayham terrace, Camden town, N.W.

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1859 CHANCE, EDWARD JOHN, F.R.C.S., Surgeon to the Metropolitan Free Hospital and City Orthopædic Hospital; 59, Old Broad street, City, E.C.

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1859 CHOLMONDELEY, JOSEPH, Surgeon-Accoucheur to Queen Charlotte's Lying-in Hospital; 3, Nottingham place, Marylebone road, W. *Council*, 1859-60-61.

1859 CHOWNE, WILLIAM DINGLE, M.D., Physician to, and Lecturer on the Principles and Practice of Medicine and Obstetrics at, Charing Cross Hospital; 8, Connaught place west, Hyde park, W. *Council*, 1860-62.

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1859 CLARK, JAMES FENN, 18, York terrace, Leamington. *Hon. Loc. Sec.*

1862 CLARKE, JOHN, Lynton, North Devon.

1859 CLAY, CHARLES, M.D., late Medical Officer in Ordinary and Lecturer on Midwifery and Clinical Medicine in St. Mary's Hospital; 101, Piccadilly, Manchester. *Council*, 1863-5.

1859 CLAY, JOHN, Surgeon-Accoucheur to the Queen's Hospital; 95, Newhall street, Birmingham.

1859 CLAYTON, OSCAR, F.R.C.S., 87, Harley street, W.

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1860 COCKELL, EDGAR, Holly Lodge, Queen's road, Dalston, N.E.

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1861 COOPER, JOHN, L.R.C.P. Ed., Clapham Rise, S.

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1863 DAVIS, ROBERT ALEX., L.R.C.P. Edinb. (exam.), County Asylum, Burntwood, near Lichfield, Stafford.

1859 DAY, WILLIAM HENRY, M.D., Lushington House, Park terrace, Newmarket.

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1859 DIXON, WILLIAM, L.R.C.P. Edin., Tickhill, Rotherham, Yorkshire.

1859 DRAGE, CHARLES, M.D., Hatfield, Herts. *Council*, 1861-64.

1859 DRUITT, ROBERT, M.R.C.P., Medical Officer of Health for St. George's, Hanover square; 37, Hertford street, Mayfair, W. *Council*, 1859-60. *Vice-Pres.* 1862-64.

1859 DRUITT, WILLIAM, F.R.C.S., Wimborne, Dorset.

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1859* EASSON, JAMES, 23, Princes street, Cavendish square, W.

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1859 ELLIOTT, ROBERT, F.R.C.S. Edin., Senior Surgeon to the Chichester Infirmary; North street, Chichester.

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1863 GALTON, JOHN HENRY, M.B. Lond., Brixton Rise, S.

1860 GARLAND, EDWARD CHARLES, Silver street, Yeovil, Somerset.

1863 GARMAN, HENRY VINCENT, Kent House, Bow road, E.

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1859 GASKOIN, GEORGE, 3, Westbourne park, W.

1864 GAUNT, JOHN SMITH, Alvechurch, Worcestershire.

1862 GAYTON, WILLIAM, 85, B[illegible] Spitalfields, N.E.

Elected

1859 GERVIS, HENRY, M.D., Assistant Obstetric Physician to St. Thomas's Hospital; 12, St. Thomas's street, Southwark, S.E. *Council*, 1864-66.

1864 GILBEE, WILLIAM, 113, Collins street East, Melbourne, Victoria.

1865 GILES, GEORGE FREDERICK, M.D., Clifton villa, Victoria Park road, Hackney, N.E.

1860 GILL, SAMUEL L., M.D., L.R.C.P. Edin., 4, Campbell terrace, Bow road, E.

1861 GOSS, SAMUEL DAY, M.D. St. And., F.R.G.S., 24, Newington place, Kennington park, S.

1859 GOULSTONE, JOHN G., M.D., 30, Clarence street, Liverpool.

1864 GRANVILLE, JOSEPH MORTIMER, L.R.C.P., Obstetrical Surgeon to the Bristol Dispensary; Surrey House, St. Paul's, Bristol.

1861 GREAM, GEORGE THOMPSON, M.D., Physician-Accoucheur to H.R.H. the Princess of Wales; 2, Upper Brook street, Grosvenor square, W. *Council*, 1862-63. *Vice-Pres.* 1864-66.

1859 GREENHALGH, ROBERT, M.D., Physician-Accoucheur and Lecturer on Midwifery to St. Bartholomew's Hospital and Physician-Accoucheur to the Samaritan Free Hospital; 76, Grosvenor street, W. *Council*, 1863. *Vice-Pres.* 1864-66.

1863 GRIFFITH, G. DE GORREQUER, M.D., 9, Lupus street, St. George's square, S.W.

1859 GRIFFITH, THOMAS TAYLOR, F.R.C.S., Consulting Surgeon to the Wrexham Infirmary; Wrexham, Denbighshire.

1859 GRIMSDALE, THOS. F., Surgeon to the Lying-in Hospital, and Lecturer on Diseases of Children at the Royal Infirmary School of Medicine; 29, Rodney street, Liverpool. *Council*, 1861-62.

1859 GUEST, EDMUND, F.R.C.S., L.R.C.P. Edin., 20, Halsey street, Chelsea, S.W.

1859 GUNN, THEOPHILUS MILLER, F.R.C.S., 40, York place, Baker street, W.

1865 GWYN, G. F., Westcroft House Hammersmith.

Elected

1859 HADEN, FRANCIS SEYMOUR, F.R.C.S., Hon. Surgeon to the Government School of Science and Art; 62, Sloane street, S.W. *Council*, 1861-63. *Vice-Pres.* 1865-66.

1863 HAILEY, HAMMETT, The Elms, Newport Pagnell, Bucks.

1859 HALL, ALFRED, M.D., Senior Physician to the Brighton Dispensary; 30, Old Steyne, Brighton. *Council*, 1864-65. *Vice-Pres.* 1866. *Hon. Loc. Sec.*

1859 HALL, FREDERICK, 1, Jermyn street, St. James's, S.W.

1862 HALL, WILLIAM, Lecturer on Botany, Leeds School of Medicine; North street, Leeds.

1860 HARDEY, KEY, Surgeon to the West City Dispensary; 4, Wardrobe place, Doctors' Commons, E.C.

1859 HARDEY, ROBERT, late Lecturer on Obstetrics, Hull and East Riding School of Medicine; 13, Charlotte street, Hull. *Council*, 1860-62. *Vice-Pres.* 1863-65. *Hon. Loc. Sec.*

1859 HARLEY, GEORGE, M.D., Professor of Medical Jurisprudence, University College, and Assistant-Physician to University College Hospital; 77, Harley street, Cavendish square, W. *Council*, 1861-63.

1859 HARPER, PHILIP H., F.R.C.S., Assistant-Surgeon to the London Home for Surgical Diseases of Women; 30, Cambridge street, Hyde park, W.

1865 HARRER, CARL, M.D., 16, City road, E.C.

1863 HARRIES, GWYNNE, M.B., Lond., Pembroke Dock, South Wales.

1859 HARRINSON, ISAAC, F.R.C.S., Castle street, Reading, Berks. *Council*, 1862-65. *Hon. Loc. Sec.*

1862 HARRIS, CHARLES, M.D., Northiam, Sussex.

1861 HARRIS, HERBERT ROBEY, 52, Bolton street, Bury, Lancashire.

1861 HARRIS, WILLIAM JOHN, 13, Marine Parade, Worthing.

1864 HARRISON, SAMUEL NORTON, Patrington, Holderness, Yorkshire.

1864 HARTLEY, J. HENRY, M.R.C.S., 13, The Pavement, Clapham common.

1865 HARVEY, ROBERT, M.D., Indian Army, Bengal Presidency.

1859 HARVEY, WILLIAM, 48, Lonsdale square, Islington, N.

1864 HASENFELD, EMMANUEL, M.D., Pesth, Hungary.

Elected

1861 HAVILAND, EDWARD SAVAGE, M.D., 13, Lyon terrace, Maida Hill, W.

1859 HAWTHORNE, ARTHUR NEVILLE, F.R.C.S., Eccleshall, Staffordshire.

1865 HAYES, HAWKESLEY ROCHE, Basingstoke, Hants.

1862 HAYMAN, CHARLES CHRISTOPHER, M.D., Eastbourne, Sussex.

1864 HEAD, EDWARD, M.B., 44, Harley street, W.

1865 HECKFORD, NATHANIEL, London Hospital, E.

1860 HESS, AUGUSTUS, M.D., Physician to the Jews' Hospital, Mile End; 14, Artillery Place, City Road, Finsbury square, E.C.

1859 HEWITT, GRAILY, M.D., Physician to the British Lying-in Hospital, Assistant Physician-Accoucheur, and Lecturer on Midwifery and Diseases of Women and Children at St. Mary's Hospital Medical School; 36, Berkeley square, W. *Hon. Sec.* 1859-64. *Treas.* 1865-66.

1862 HEWITT, TOM SMITH, M.D., Ivy Cottage, Winkfield, Windsor, Berks.

1863 HIBBERD, EDWARD, M.D., 67, Union street, Southwark, S.E.

*1860 HICKS, JOHN BRAXTON, M.D., F.R.S., Assistant Physician-Accoucheur to, and one of the Lecturers on Midwifery and the Diseases of Women and Children at, Guy's Hospital; Physician to the Royal Maternity Charity and to the Royal Infirmary for Diseases of Children and Women, Waterloo Road; 9, St. Thomas's street, Southwark, S.E. *Council*, 1861-62. *Hon. Sec.* 1863-65. *Vice-Pres.* 1866.

1860 HIGGS, THOMAS FREDERIC, L.R.C.P. Edin.; Wolverhampton street, Dudley, Worcestershire.

1859 HIRD, FRANCIS, F.R.C.S., formerly Surgeon to the Royal Infirmary for Children, Surgeon to Charing Cross Hospital; 13, Old Burlington street, W. *Council*, 1861-62.

1865 HODDER, EDWARD M., M.D., Toronto, Canada.

1859 HODGES, RICHARD, M.D., 1, Montagu street, Portman square, W.

1859 HODGSON, GEORGE FREDERICK, 52, Montpellier road, Brighton.

1864 HOFFMEISTER, WILLIAM CARTER, M.D., Surgeon to the Queen in the Isle of Wight; Cowes, Isle of Wight.

Elected

1859 HOLMAN, ANDREW, 10, John street, America square, E.C.

1859 HOLMAN, CONSTANTINE, M.D., Reigate, Surrey.

1860 HOLMAN, HENRY MARTIN, M.D., Hurstpierpoint, Sussex.

1864 HOOD, WHARTON PETER, M.D., 65, Upper Berkeley street, W.

1861 HORTON, GEORGE EDWARD, Dudley, Worcestershire.

1864 HOUGHTON, HENRY GEORGE, M.D., 6, Mount street, Grosvenor square.

1862 HUBERT, WILLIAM ARTHUR, Markgate street, Bedfordshire.

1859 HUSSEY, EDWARD LAW, F.R.C.S., Surgeon to the Radcliffe Infirmary; 104, St. Aldate's, Oxford.

1859 HUTCHINSON, JONATHAN, Assistant-Surgeon to the London Hospital; 4, Finsbury Circus, E.C.

1865 HUTCHINSON, THOMAS STEERS, L.R.C.P. Edin., Newington, Sittingbourne, Kent.

1861 HUTTON, CHARLES, M.D., Physician to the General Lying-in-Hospital; 26, Lowndes street, Belgrave square, S.W.

1859 ILOTT, JAMES WILLIAM, Bromley, Kent.

1859 IMAGE, WILLIAM EDMUND, F.R.C.S., Senior Surgeon to the Suffolk General Hospital; Bury St. Edmunds, Suffolk.

1864 JACKSON, EDWARD, M.B., Fern Bank, Glossop road, Sheffield.

1864 JACKSON, ROBERT, M.D., 53, Notting Hill square, W.

1861 JACKSON, THOMAS HAYES, M.D., 18, Market place, Darlington, Durham.

1859 JAMES, HENRY, F.R.C.S., Holmwood, Weybridge, Surrey. *Council*, 1862-63.

1862 JAY, FREDERICK FITZHERBERT, L.R.C.P., Watton, Thetford, Norfolk.

1863 JENKINS, ROBERT W., 22, Philpot lane, E.C.

1859 JENNINGS, JOSEPH C. S., Abbey House, Malmesbury, Wilts.

1860 JEPSON, HENRY, F.R.C.S., Surgeon to the Kingston Dispensary; Hampton, Middlesex, S.W.

SON, EDWARD, M.D., 19, Cavendish place, Cavendish are, W.

HENRY SCHOLFIELD, M.D., West street, Congle-heshire.

ARD, M.D., The Park, Sydenham, Kent.

GE, 12, New Hall street, Birmingham.

WILLIAM, 8, Brynteg terrace, Upper Bangor, nshire.

Elected

1859 KEALY, JOHN ROBERT, M.D., Ashley House, Gosport, Hants. *Hon. Loc. Sec.*

1859 KEELE, GEORGE THOMAS, 1, Bruce-Villas, 81, St. Paul's road, Highbury, N.

1859 KENDALL, THOMAS MARSTERS, F.R.C.S., Medical Attendant to their R.H. the Prince and Princess of Wales at Sandringham, Surgeon to the West Norfolk and Lynn Hospital; King's Lynn, Norfolk.

1861 KERBEY, WILLIAM HOLMAN, Weobley, Herefordshire.

1865* KERNOT, GEORGE CHARLES, M.D., 3, Chrisp street, Poplar, E.

1859 KIALLMARK, HENRY WALTER, 46, Princes square, Westbourne grove, W.

1860 KINGSFORD, EDWARD, F.R.C.S., Surgeon to the Sunbury Dispensary; Sunbury, Middlesex, S.W.

1862 KIRKPATRICK, JOHN RUTHERFORD, M.B., T.C.D., Lying-in-Hospital, 32, Rutland square, Dublin.

1860 KISCH, JOSEPH, 2, Circus place, Finsbury Circus, E.C.

1862 LAMB, JOHN STEWART, M.D., 4, Windsor terrace, Maida vale, W.

1859 LANGMORE, J. CHARLES, M.B., F.R.C.S, 48, Sussex gardens, W. *Council*, 1861-64.

1862 LANPHIER, RICHARD, M.B. Dub., Alford, Lincolnshire.

1859 LEE, NEWTON B. C., 11, Talbot terrace, Talbot road, Bayswater, W.

1859 LEECH, EDWARD, Pallant, Chichester, Sussex.

1864 LEESON, JOSEPH FREDERICK, M.D., Bentinck place, Bradford, Yorkshire.

1860 LEISHMAN, WILLIAM, M.D., Physician to the Glasgow Royal Infirmary, to the University Lying-in Hospital, and to the Dispensary for the Diseases of Women and Children; 7, Blythswood square, Glasgow. *Council*, 1866.

1859 LOCOCK, SIR CHAS., Bart., M.D., First Physician-Accoucheur to H.M. the Queen; 26, Hertford street, Mayfair, W. *Honorary President.*

1859 LOMBE, THOMAS ROBERT, M.D., Coltishall, Norfolk.

1861 LOVE, GILBERT, Wimbledon, Surrey, S.W.

1862 LOWE, GEORGE, Burton-on-Trent, Staffordshire.

Elected

1860 LOWE, JOHN, M.D., Surgeon to the West Norfolk and Lynn Hospital; King street, King's Lynn, Norfolk.

1862 MACKENZIE, GEORGE WISE, Thetford, Norfolk.

1859 MACKINDER, DRAPER, M.D., Consulting Surgeon to the Gainsborough Dispensary; Gainsborough, Lincolnshire.

1859 MACKINLAY, JOHN, M.D., Isleworth, Middlesex.

1859 MACLAREN, ALEXANDER C., 29, Harley street, W.

1859 MACRAE, JOHN, 4, High Street, Lewes, Sussex.

1861 MCVEAGH, DENNIS, L.K. and Q.C.P. Ireland, 33, Bishop street, Coventry, Warwickshire.

1859 MADGE, HENRY, M.D., 32, Fitzroy square, W. *Council*, 1863-65.

1860 MARLEY, HENRY FREDERICK, Padstow, Cornwall.

1859 MARLEY, RICHARD, Bromyard, Herefordshire.

1862 MARRIOTT, ROBERT BUCHANAN, Swaffham, Norfolk.

1860 MARSHALL, JAS., M.D., 6, Rubislaw place, Aberdeen.

1862 MARSHALL, JOHN, L.R.C.P. Lond., 29, Castle street, Dover.

1859 MARSHALL, JOHN BRAKE, 40, Morton road, Islington, N.

1859 MARSHALL, PETER, 42, Bedford square, W.C.

1860 MARTIN, HENRY VICTOR, F.R.C.S., Staines, Middlesex.

1864 MARTIN, LAURENCE J., M.D., 126, Collins street east, Melbourne, Victoria.

1859 MARTYN, WILLIAM, M.D., F.R.C.S., 6, Trevor terrace, Rutland Gate, Brompton, S.W.

1861 MATTHEWS, JOHN, M.D., 4, Mylne street, Myddleton square, E.C.

1859 MEADOWS, ALFRED, M.D., Physician-Accoucheur for the Out-Patients to the General Lying-in Hospital, York road; 27, George street, Hanover square, W. *Council*, 1862-64. *Hon. Sec.* 1865-66. *Hon. Lib.* 1865.

1859 MERRIMAN, SAMUEL WILLIAM JOHN, M.D., Consulting Physician-Accoucheur to the Westminster General Dispensary, and Physician-Accoucheur to the Western General Dispensary; 13, Godolphin road, New road, Hammersmith. *Council*, 1859-60.

1865 MIDDLETON, —, M.D., Brussels.

1861 MIDDLETON, WILLIAM, F.R.C.S., 25, Lansdowne place, Leamington, Warwickshire.

Elected

1859 MILES, CHARLES, 13, Conduit street west, Westbourne terrace, W.

1859 MITCHELL, JOSEPH THOMAS, F.R.C.S., 8, Percy place, Clapham road, S. *Council*, 1863-66

1865 MOORE, EDWARD HOWARD, L.R.C.P. Edin., 9, Newmarket terrace, Cambridge heath, N.E.

1859 MOORHEAD, JOHN, M.D., Surgeon to the Weymouth Infirmary and Dispensary, Weymouth, Dorset.

1863 MORGAN, EDWARD, Llanelly, Caermarthenshire.

1865 MOSELEY, GEORGE, 51, Priory road, Kilburn.

1865 MOXEY, DAVID ANDERSON, M.D., Maryfield house, Turnham green, Middlesex.

1859 MOYLES, THOS., M.D., 109, Broad street, Birmingham.

1863 MURPHY, WILLIAM, M.D., Peitermaritzburg, South Africa.

1859 MURRAY, GUSTAVUS CHARLES P., M.D., Physician-Accoucheur to the Great Northern Hospital, Medical Officer to the British Lying-in Hospital, Physician for Diseases of Women and Children to the St. George's and St. James's Dispensary; 17, Green street, Grosvenor square, W. *Council*, 1864-65. *Hon. Sec.*, 1866.

1859 MUSGRAVE, JOHNSON THOMAS, 29, Finchley road, N.W. *Council*, 1859-60.

1859 NAPPER, ALBERT, Broad Oak, Cranley, Guildford, Surrey. *Council*, 1866.

1863 NASON, JOHN JAMES, M.B. Lond., Bridge street, Stratford-on-Avon.

1859 NASON, RICHARD BIRD, Nuneaton, Warwickshire.

1859 NEAL, JAMES, 85, New Hall street, Birmingham.

1859 NEWMAN, WILLIAM, M.D., St. Martin's, Stamford-Baron, Northamptonshire.

1859 NEWTON, EDWARD, F.R.C.S., 30, Fitzroy square, W. *Council*, 1865-66.

1861 NICHOLS, GEORGE W., Almond Tree House, Rotherhithe, S.E.

1859 NICHOLSON, WILLIAM HUNTER, 58, Ossulston street, Somers town, N.W.

1859 NUNN, THOMAS WILLIAM, Assistant-Surgeon to the Middlesex Hospital; 8, Stratford place, Oxford street, W.

1860 OAKSHOTT, JOHN, Highgate, N.

Elected

1859 O'FLAHERTY, THOMAS AUSTIN, M.D., 2, Baker street, Portman square, W.

1859 OLDHAM, HENRY, M.D., F.R.C.P., Obstetric Physician and Lecturer on Midwifery and Diseases of Women and Children at Guy's Hospital; 26, Finsbury square, E.C. *Vice-Pres.* 1859. *Council*, 1860, 1865-66. *Treas.* 1861-62. *Pres.* 1863-64.

1859 OLDHAM, JAMES, Norfolk square, Brighton. *Council*, 1866.

1865 ORTEZ, MANUEL MARIA, M.D., Port of Spain, Trinidad.

1863 OSWALD, JAMES WADDELL JEFFRIES, 3, Alexander terrace, West cliff, Ramsgate, Kent.

1863 OWEN, ALBERT PHILIP, Margate, Kent.

1861 OWEN, WILLIAM B., 61, Cleveland square, Hyde park, W.

1859 PALFREY, JAMES, M.D., Assistant Obstetrical Physician to the London Hospital, Senior Assistant Physician to the Metropolitan Free Hospital, and Obstetric Physician to the Farringdon General Dispensary; 25, Finsbury place.

1862 PARKER, THEOPHILUS RT. BUSH, The Vicarage, Abbotsbury, Dorset.

1863 PARSON, EDWARD, M.D. Lond., Physician to the Samaritan Hospital for Women and Children; Medical Officer for Out-Patients to Queen Charlotte's Lying-in Hospital; Lecturer on Midwifery and Diseases of Women and Children at the Charing Cross Hospital; 3, York street, Portman square, W.

1865 PATERSON, JAMES, M.D., Rosewall, Partick, Glasgow.

1860 PAYNE, CHARLES HENRY, M.D., Wimbledon, Surrey, S.W.

1860 PEARSE, GEORGE, L.R.C.P. Edin., 10, Regent street, Westminster, S.W.

1864 PEARSON, DAVID RITCHIE, M.D., 23, Upper Phillimore place, Kensington, W.

1859 PEIRCE, R. KING, 16, Norland place, Notting hill, W.

1864 PHILLIPS, HOWELL CHARLES, M.D., 14, Colville square, Kensington park, W.

1859 PINCHARD, BENJAMIN, M.D., Cottenham, Cambridgeshire.

1864 PLAYFAIR, WILLIAM, M.D., Assistant-Physician for the Diseases of Women and Children to King's College Hospital; 5, Curzon street, May fair, W.

Elected

1860* PLOWMAN, WM. T., M.D., H. Hardstaffe's, Esq., Hache Court, near Taunton.

1859 POLLARD, WILLIAM, Jun., Surgeon to the Torbay Infirmary and Dispensary, Torquay, Devon.

1860 POLLOCK, TIMOTHY, M.D., 26, Hatton garden, E.C. *Council*, 1866.

1860 PORTER, CHARLES, 54, Digbeth, Birmingham.

1859 POTTER, JEPHSON, M.D., 109, Upper Parliament street, Liverpool.

1864 POTTER, JOHN BAPTISTE, M.D., 3, Craven hill, Hyde park, W.

1859 POUND, GEORGE, Odiham, Hants.

1863 POWELL, JOSIAH T., M.D., 325, City road, E.C.

1864 POWELL, LLEWELLYN, Christchurch, Canterbury, New Zealand.

1859 PRANCE, ROBERT ROOKE, M.D., Heath street, Hampstead, N.W.

1864 PRICE, WILLIAM NICHOLSON, Lecturer on Midwifery at the Leeds School of Medicine; 7, East parade, Leeds.

1863 PRICE, WILLIAM PRESTON, M.D., Surgeon to the Metropolitan Infirmary for Scrofulous Children, Margate.

1859 PRIESTLEY, W. O., M.D., Professor of Midwifery in King's College, London, and Physician-Accoucheur to King's College Hospital, and Consulting Physician-Accoucheur to the St. Marylebone Infirmary; 17, Hertford street, Mayfair, W. *Council*, 1859-61, 1865-66.

1862 PRINCE, FREDERICK, Sawston, Cambridgeshire.

1864 PUGH, WILLIAM RUSS, M.D., 131, Collins street east, Melbourne, Victoria.

1864 QUARRELL, WILLIAM, Sidburn. Worcester (travelling).

1859 RADFORD, THOMAS, M.D., Consulting Physician to St. Mary's Hospital, Manchester; Moor field, Higher Broughton, Manchester. *Vice-Pres.* 1859.

1859 RAMSAY, JOHN ALLEN, L.R.C.P. Ed., Great Shelford, Cambridge.

1860 RAMSBOTHAM, JOHN HODGSON, M.D., 16, Park place, Leeds.

1859 RANDALL, JOHN, M.D. Lond., Lecturer on Medical Jurisprudence, St. Mary's Hospital Medical School; Medical Officer, St. Marylebone Infirmary; 14, Portman street, Portman square, W.

1860 RANSOM, ROBERT, F.R.C.S., 5, Jesus lane, Cambridge.

Elected

1861 RASCH, ADOLPHUS A. F., M.D., Hon. Phys. to the Eastern Dispensary of the German Hospital; 7, South street, Finsbury square, E.C.

1859 RAY, EDWARD, F.R.C.S., Dulwich, Surrey, S. *Council*, 1864-66.

1860* RAYNER, JOHN, 19, Kingsland crescent, Kingsland road, N.E.

1859 RAYNES, HENRY, Gringley-on-the-hill, Bawtry, Yorkshire.

1859 REE, HENRY PAWLE, L.R.C.P. Ed., Walham green, Fulham, S.W.

1859 REMINGTON, THOMAS, Medical Officer to the Clapham General Dispensary; 1, Grove place, North Brixton, S.

1860 RENTON, JOHN, Shotley bridge, Gateshead, Durham.

1860 RICHARD, EDWARD WILLIAMS, Prospect House, Finchingfield, Essex.

1862 RICHARDS, DAVID, 8, St. George's place, Brighton, Sussex.

1860 RICHARDS, JOHN SMITH CROSLAND, 36, Bedford square, W.C.

1859 RICHARDS, SAMUEL, M.D., 36, Bedford square, W.C. *Council*, 1864-66.

1862 RICHARDS, SMITH, 36, Bedford square.

1859 RICHARDSON, RICHARD, L.R.C.P. Edinb., Rhayader, Radnorshire.

1859 RICHARDSON, WILLIAM THOMAS, Ivy House, Highgate, N.

1859 ROBERTS, DAVID LLOYD, M.D., Surgeon to St. Mary's Hospital, Manchester; 23, St. John's street, Deansgate, Manchester. *Hon. Loc. Sec.*

1860 ROBERTS, ROBERT PRICE, Rhyl, Flintshire.

1860 ROBINS, GEORGE, L.R.C.P. Ed., 45, Charlotte street, Fitzroy square, W.

1859 ROBINSON, THOMAS, M.D., 64, Lamb's Conduit street, W.C.

1860 ROE, WILLIAM HAMILTON, M.B., M.R.C.P., 15, Leinster terrace, Brighton.

1859 ROGERS, WILLIAM RICHARD, M.D., Physician to the Samaritan Free Hospital; 56, Berners street, Oxford street, W.

1859 ROOTS, WILLIAM SUDLOW, F.R.C.S., F.L.S., Surgeon to the Royal Establishment at Hampton Court, Kingston-on-Thames, S.W.

1860 ROPER, ALFRED GEORGE, 112, High street, Croydon, Surrey.

1865 ROPER, GEORGE, 180, Shoreditch, N.E.

1859 ROSE, HENRY COOPER, M.D., High street, Hampstead, N.W.

Elected

1859 Ross, Daniel, Surgeon to the Metropolitan Police; 10, Commercial place, Commercial road east, E.

1859 Ross, George, M.D., Surgeon to the Western City Dispensary; 11, Hart street, Bloomsbury, W.C.

1859 Routh, Charles Henry Felix, M.D., Physician to the Samaritan Free Hospital for Women and Children; 52, Montagu square, W. *Council*, 1859-60-61.

1861 Russell, William Alexander, L.R.C.P. Edin.; St. Peter street, St. Alban's, Herts.

1864 Salter, J. H., Darcy House, Tolleshunt Darcy, Kelvedon, Essex.

1860 Sanders, Godfrey, F.R.C.S., 17, Brewer street, Maidstone, Kent.

1862 Sankey, William, Extra L.R.C.P., 6, Upper Portland place, Wandsworth, S.W.

1865 Sansom, Arthur Ernest, M.D., 29, Duncan terrace, Islington, N.

1863 Savage, Henry, M.D. Lond., Physician to the Samaritan Hospital for Women; Anerley, W.

1859 Scott, John, F.R.C.S., Surgeon to the Hospital for Women, Soho square; 65, Harley street, Cavendish square, W.

1860 Sedgwick, Leonard William, M.D., 11, Hinde street, Manchester square, W.

1863 Sequeira, Henry Little, 1, Jewry street, Aldgate, E.C.

1860 Sewell, Charles Brodie, M.D., 76, Guildford street, Russell square, W.C.

1865 Seymour, Almeric W., M.D., M.A. Cant., 53, Montpellier road, Brighton.

1862 Sharman, Malim, 18, New Hall street, Birmingham.

1859 Sharpin, Henry Wilson, F.R.C.S., Surgeon to the Bedford General Infirmary, Bedford.

1860 Shaw, George, Portland House, Battersea, S.W.

1859 Shaw, James, L.R.C.P. Edin., 52, York street, Cheetham, Manchester.

1859 Shearman, Edward James, M.D., Rotherham, Yorkshire.

1859 Sheehy, William Henry, L.R.C.P. Edin., 4, Claremont square, Pentonville, N.

1862 Shillingford, Isaac Shortland, 124, Hill street, Peckham, S.E.

Elected

1859 SHIPTON, WILLIAM PARKER, Surgeon to the Buxton Bath Charity; Buxton, Derbyshire.

1860 SHIRLEY, HENRY JAMES, 4, Grove terrace, Kentish Town, N.W.

1861 SHORTT, JOHN, M.D., Assistant-Surgeon H.M. I. Army, Chingleput, Madras District.

1861 SISSON, ANDREW, Reigate, Surrey.

1860 SKINNER, THOMAS, M.D., 1, St. James's road, Liverpool. *Council*, 1865-66. *Hon. Loc. Sec.*

1859 SLEEMAN, PHILIP ROWLING, F.R.C.S., Montrose House, Queen's road, Clifton.

1861 SLOMAN, SAMUEL GEORGE, Farnham, Surrey.

1861 SLYMAN, WILLIAM DANIEL, 18, Warden road, Kentish town, N.W.

1860 SMART, THOMAS TOVEY, L.R.C.P. Edinb., South villa, Bedminster, Bristol.

1859 SMILES, WILLIAM, M.D., Physician to the Royal General Dispensary, St. Pancras; 43, Bedford square, W.C.

1865 SMITH, FLY, M.B., 10, Kensington Park terrace, W.

1862 SMITH, HENRY, M.D., 8, St. Mary's terrace, Paddington, W.

1862 SMITH, JOSIAH SIDNEY, Tiverton, Devon.

1860 SMITH, JOHN, Coseley, near Bilston, Staffordshire.

1860 SMITH, JOSEPH EVANS, Oxford road, Hay, Breconshire.

1859 SMITH, PROTHEROE, M.D., Physician to the Hospital for Women, Soho square; 25, Park street, Grosvenor square, W.

1859 SMITH, SAMUEL, F.R.C.S., Senior Surgeon to the Leeds General Infirmary; Park place, Leeds. *Council*, 1860-62. *Hon. Loc. Sec.*

1859 SMITH, WILLIAM JOHNSON, M.D., Consulting Physician to the Weymouth Infirmary and Dispensary; Greenhill, Weymouth, Dorset.

1859 SMITH, W. TYLER, M.D., F.R.C.P., Physician-Accoucheur and Lecturer on Midwifery and Diseases of Women and Children to St. Mary's Hospital; 21, Upper Grosvenor street, W. *Treasurer & Vice-Pres.* 1859-60. *Pres.* 1861-62. *Council*, 1863-66.

1860 SNELL, EDMUND, 20, Stepney green, E.

1860 SNOW, JOHN ELLIOT, Walton, near Ipswich.

Elected

1859 SOMERVILLE, CHARLES, M.D., Bloxwich, Walsall, Staffordshire.

1859 SPENCER, GEORGE, 1, Horbury terrace, Notting hill, W.

1860 SPENCER, LAWRENCE, M.D., 9, Winckley square, Preston, Lancashire.

1862 SPRY, GEORGE FREDERICK, M.D., Assistant-Surgeon 9th Queen's Royal Lancers.

1859 SQUIRE, WILLIAM, 6, Orchard street, Portman square, W. *Council*, 1866.

1859 STANTON, JOHN, M.D., 9, Montagu square, W.

1860 STEDMAN, ROBERT SAVIGNAC, Sharnbrook, Bedfordshire.

1860 STEPHENS, JOSEPH, M.D., 5, Pavilion parade, Brighton.

1859 STONE, JOSEPH, M.D., 84, Bloomsbury, Oxford street, Manchester.

1860 STONE, THOMAS, F.R.C.S., Resident Surgeon to Christ's Hospital.

1859 STOWERS, NOWELL, 125, Kennington park road, Kennington, S.

1859 STUTTER, FREDERICK AUGUSTUS, Farnboro' House, Upper Sydenham, Kent.

1862 SUTHERLAND, WILLIAM, M.D., 22, George street, Croydon, Surrey.

1862 SUTTON, FIELD FLOWERS, M.D., Balham hill, Clapham, S.

1859 SUTTON, JOHN MAULE, M.D., Tenby, S. Wales.

1859 SWAYNE, JOSEPH GRIFFITHS, M.D., Physician-Accoucheur to the British General Hospital; Clifton, Bristol. *Council*, 1860-61. *Vice-Pres.* 1862-64. *Hon. Loc. Sec.*

1860 SWEETING, GEORGE BACON, M.R.C.P., King's Lynn, Norfolk.

1863 SWYER, SEPTIMUS, L.R.C.P. Edinb., 19, Brick lane, Whitechapel, E.

1859 SYDENHAM, JOHN PUDSEY WELCHMAN, Islip, Oxon.

1859 SYMONDS, FREDERICK, F.R.C.S., Surgeon to the Radcliffe Infirmary; 35, Beaumont street, Oxford. *Council*, 1862-65. *Hon. Loc. Sec.*

1861 TANNER, JOHN, M.D., 118, Newington Causeway, S.E.

1859 TANNER, THOS. HAWKES, M.D., F.L.S., 9, Henrietta street, Cavendish square, W. *Hon. Sec.* 1859-62. *Vice-Pres.* 1863-65.

1859 TAPSON, ALFRED JOSEPH, M.B. Lond., 35, Gloucester gardens, Westbourne terrace, W. *Council*, 1862-64.

Elected

1863 TAPSON, JOSEPH ALFRED, 83, High street, Clapham, S.
1862 TASKER, RICHARD THOMAS, Melbourne, near Derby.
1859 TAYLOE, EDWARD, Clapham common, S.
1859 TAYLOR, CHARLES, M.D., 79, Camberwell road, S.
1859 TAYLOR, DAVID, 180, Kennington park road, S.
1862 TAYLOR, THOMAS, F.R.C.S., 19, Bennett's hill, Birmingham.
1862 THANE, GEORGE DANCER, M.D., 15, Montague street, Russell square.
1860 THOMAS, FREDERICK, M.D., Tower terrace, Upper Norwood.
1860 THORNE, GEORGE LEWORTHY, M.D., Swanage, Dorset.
1862 THORNTON, WILLIAM HENRY, M.D., Springfield terrace, Dewsbury, Yorkshire.
1860 TIFFEN, ROBERT, M.D., Wigton, Cumberland.
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1860 TORBOCK, THOMAS REDDISH, M.D., 30, Skinnergate, Darlington.
1865 TOWNSEND, HENRY MEREDITH, Thurlow House, Clapham rise, S.
1862 TRACY, RICHARD T., M.D., Physician to the Lying-in Hospital, Melbourne, Victoria.
1859 TRAER, JAMES REEVES, F.R.C.S., 47, Hans place, Sloane street, S.W. *Council*, 1865. *Hon. Lib.* 1866.
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1861 TURNER, RICHARD, High street, Lewes, Sussex.
1865 TURNER, JOHN SIDNEY, Anerley road, Upper Norwood, Surrey.
1863 TUTIN, JOHN HASLEDINE, Surgeon to the Ripon Dispensary, Westgate, Ripon, Yorkshire.
1861 TWEED, JOHN JAMES, Jun., 14, Upper Brook street, W.
1860 VARENNE, EZEKIEL G., Kelvedon, Essex.

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1860 VINCENT, PATRICK, Wells-next-Sea, Norfolk.

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1860 WALES, THOMAS GARNEYS, Jun., Downham, Norfolk.

1863 WALKER, THOMAS HOUGHTON, M.D., Encomb House, Reading.

1860 WALKER, WILLIAM HENRY, L.R.C.P. Edinb., Aldborough, near Darlington, Yorkshire.

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1863 WALTERS, REGINALD BAYLEY, 18, William Street, Regent's park, N.W.

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1860 WARD, JOSEPH, Hill House, Epsom, Surrey.

1860 WARD, JOHN, Penistone, Sheffield, Yorkshire.

1859 WARDEN, CHARLES, M.D., 39, Temple street, Birmingham.

1862 WATKINS, CHARLES STEWART, 11, Chandos street, Strand, W.C.

1861 WATTS, GEORGE HENRY, Thatcham, near Newbury, Berks.

1850 WEBB, HENRY SPEAKMAN, Welwyn, Herts.

1859 WEBB, J. CRASKE, M.D., 14, Lower Belgrave street, S.W.

1860 WELCHMAN, CHARLES EDWARD ELLIOT, Bore street, Lichfield, Staffordshire.

1859 WELLS, T. SPENCER, F.R.C.S., Surgeon in Ordinary to H.M.'s Household; Surgeon to the Samaritan Free Hospital for Women and Children; 3, Upper Grosvenor street, W. *Council*, 1859.

1859 WEST, ROBERT UVEDALE, M.D., Alford, Lincolnshire. *Council*, 1859. *Vice-Pres.* 1860-62.

1859 WESTMACOTT, JOHN GUISE, M.D., Medical Officer to the Paddington Provident Dispensary; 19, St. Mary's terrace, Paddington, W.

1860 WHEELER, DANIEL, Chelmsford, Essex.

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1860 WHITE, FREDERICK GEORGE, L.R.C.P. Edinb., Castle House, Chepstow, Monmouthshire.

1859 WHITEHEAD, JAMES, M.D., Physician to the Manchester Clinical Hospital; 87, Mosley street, Manchester. *Council*, 1859-61.

1865 WHITEHEAD, WALTER, Mansfield, Woodhouse, Notts.

1864 WHITMARSH, WILLIAM MICHAEL, M.D., Hounslow, Middlesex.

1864 WILKS, ALFRED G., M.B. and M.S. Camb., Guy's Hospital (travelling).

1864 WILLIAMS, ARTHUR WYNN, M.D., Physician-Accoucheur to the St. George's and St. James's Dispensary; 1, Montagu square, W.

1861 WILLIAMS, DAVID JOHN, M.D., Queenscliff, Geelong, Victoria, Australia. *Hon. Loc. Sec.*

1864 WILLIAMS, EDWARD, M.D., Holt Street House, Wrexham.

1860 WILLIAMS, ROBERT HANKINSON, L.R.C.P. Edinb., Great Eccleston, near Garstang, Lancashire.

1860 WILLS, JOHN, M.D., St. Helier's, Jersey.

1859 WILSON, JAMES GEORGE, M.D., Professor of Midwifery, University of Glasgow; Physician-Accoucheur to the Glasgow Lying-in Hospital and Dispensary; Clarence place, Sauchiehall street, Glasgow. *Council*, 1863-64. *Vice-Pres.* 1865-66.

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1865 WILSON, THOMAS, L.R.C.P. Ed. (exam.), Alton, Hants.

1860 WINTERBOTHAM, JOHN, Castleton, near Sheffield, Derbyshire.

1860 WISEMAN, WILLIAM WOOD, Springstone House, Ossett, near Wakefield, Yorkshire.

1859 WITTEN, EDWARD W. (travelling).

1860 WOOD, WILLIAM JAMES, Brightwaltham, Wantage, Berks.

1864 WOODMAN, WILLIAM BATHURST, M.D., Resident Medical Officer to the London Hospital, Mile End, E.

1859 WORSHIP, J. LUCAS, Riverhead, Sevenoaks, Kent.

1860 WRIGHT, GEORGE, Middleham, W. Bedale, Yorkshire.

1861 YOUNG, WILLIAM BUTLER, 5, Castle street, Reading, Berks.

CONTENTS.

	PAGE
List of Officers for 1866	v
List of Presidents	vi
List of Referees of Papers for 1866	vii
List of Honorary Local Secretaries	viii
Trustees of the Society's Property	ix
List of Honorary Fellows	ix
List of Ordinary Fellows	xi
Contents	xxxv
List of Plates	xl
Advertisement	xlii

January 4th, 1865—

Annual General Meeting	1
I. Notes of a Case of Extra-uterine Fœtation. By W. S. PLAYFAIR, M.D., M.R.C.P.	1
II. Double Monstrosity, with account of the Delivery. By W. WILLS, Esq., Totness. (Communicated by Dr. GRAILY HEWITT)	6
III. Case of Embolism of the Pulmonary Artery after Ovariotomy. By E. PARSON, M.D. Lond.	8
IV. Amputation of the Arm in Pregnancy. By ALBERT NAPPER, Esq.	12
Annual Meeting. Report, Alterations and Additions in the Laws relative to the appointment of a Honorary Librarian, &c.	14
Annual Address of the President, HENRY OLDHAM, M.D.	19

February 1st, 1865—

Removal of a Polypus. (Dr. GREENHALGH)	25
Numerous Fibroid Tumours in a Uterus. (Dr. B. WOODMAN)	26

February 1st, 1865 (*continued*)— PAGE

V. Case of Chancre on the Os Uteri. By Dr. W. BATHURST WOODMAN 26

VI. On a New Method of Securing the Pedicle in Ovariotomy. By I. BAKER BROWN, Esq., F.R.C.S. . . 28

VII. On Puerperal Fever. By SNOW BECK, M.D. . . 31

Address of the President, ROBERT BARNES, M.D., on taking the Chair 37

March 8th, 1865—

Dermoid Cyst. (Dr. TYLER SMITH) . . 45

VIII. On a Case of Recovery of a Still-born Child; unusual marking of the Skin, simulating the effects of injury. By JOHN ROUSE, Esq., New Zealand. (Communicated by Dr. PRIESTLEY) 45

IX. Membrane expelled from Uterus, a few days before delivery at full term. By A. HARRIS, Esq., Camborne. 47

Report on ditto. By GRAILY HEWITT, M.D., and ALFRED MEADOWS, M.D. 48

X. Labour in Primiparous Women late in the Reproductive Period of Life. By GEORGE ROPER, Esq., M.R.C.S. (Communicated by Dr. BARNES) . . . 51

XI. Case of Imperforate Bowel; Operation, Death. By ALFRED MEADOWS, M.D., Hon. Sec. . . 53

Fibroid Tumour removed from the Uterus by Enucleation and Excision. (Dr. BARNES) . . 55

XII. Case of Monstrosity. By WILLIAM GAYTON, Esq. (Communicated by Dr. B. WOODMAN) . . 56

XIII. On Two Cases of Face Presentation in the Mento-posterior Position, with Remarks. By J. BRAXTON HICKS, M.D., F.R.S., Hon. Sec. 57

April 5th, 1865—

Improvement on the mode of fastening the Rope in his Ecraseur. (Dr. BRAXTON HICKS) . . 71

New Form of Uterine Tent from the stem of the Laminaria Spiralis. (Dr. GREENHALGH) . . 72

Instrument for dividing the Cervix Uteri. (Dr. BARNES) 72

XIV. On a new form of Curette for the removal of Uterine Fungoid Granulations. By J. MARION SIMS, M.D. . 72

XV. Case of Laceration of the Integument of the Fœtus occurring during delivery. By R. KING PEIRCE, Esq., M.R.C.S. (Communicated by ALFRED MEADOWS, M.D.) 74

Report on ditto. By Dr. GEORGE HARLEY and Dr. MEADOWS 76

April 5th, 1865 (*continued*)— PAGE

XVI. Case of Anencephalic Fœtus. By HAMMETT HAILEY, Esq., F.L.S. 78

XVII. Case of Œdema of the lower half of the body, after a fall in the seventh month of Pregnancy: Premature Labour; Recovery. By ADOLPH RASCH, M.D., M.R.C.P. . 80

XVIII. Case of Monstrosity, with remarks on the influence of Maternal Impressions on the Fœtus in Utero. By ALFRED MEADOWS, M.D., M.R.C.P. Hon. Sec. . . 84

May 3rd, 1865—

XIX. On a rare form of Extra-uterine Fœtation. By J. BRAXTON HICKS, M.D., F.R.S. Hon. Sec. . 95

Report on ditto. By Dr. BARNES and Dr. B. HICKS . 100

XX. On the Combination of Chorea with Pregnancy. By BATHURST WOODMAN, M.D. . . . 102

XXI. Case of Ovarian Dropsy; Ovariotomy; Recovery. By H. W. SHARPIN, Esq., F.R.C.S. . . . 105

XXII. Case of Hernia Cerebri and Hernia Umbilicalis, with attachment of the fœtal membranes to the scalp. By THOMAS HAWKES TANNER, M.D. . . 109

XXIII. Large Fibrous Tumour of Uterus; spontaneous sloughing; death from peritonitis. By J. BRAXTON HICKS, M.D., F.R.S. Hon. Sec. 110

June 7th, 1865—

Large Fibroid Tumour, expelled spontaneously from the Uterus. (Dr. BARNES) . . . 113

XXIV. Two Cases of Hydatidiform Degeneration of the Chorion, associated with Albuminuria. By W. BATHURST WOODMAN, M.D. 113

XXV. A Third Case of Hydatidiform Degeneration of the Chorion, associated with Albuminuria. By ROBERT BARNES, M.D. President . . . 117

XXVI. On Dysmenorrhœa, Metrorrhagia, Ovaritis, and Sterility, depending upon a peculiar formation of the Cervix Uteri, and the treatment by dilatation or division. By ROBERT BARNES, M.D. President . . 120

XXVII. Appendix to ditto, in illustration of the behaviour of the Conical Cervix with minute Os under labour. By ROBERT BARNES, M.D. . . . 150

A New Hysterotome and Intra-Uterine Spring Tent. (Dr. AVELING) 155

July 5th, 1865 (*continued*)— PAGE

Portable Case of Instruments for Operations on the Uterus and Vagina. (Messrs. WEISS) . . 157

Dermoid Cyst, attached to the Right Ovary, removed after death. (Dr. B. WOODMAN) . . . 158

XXVIII. Serous Tumour in the Occipital Region. By J. WAITS, Esq., L.S.A. 158

XXIX. On a rare form of Twin Monstrosity. By RICHARD ELLIS, L.R.C.P. Ed., Newcastle-on-Tyne. With Notes by D. EMBLETON, M.D. . . . 160

XXX. Case of Extra-Uterine Fœtation. By EDGAR BECKIT TRUMAN, Esq., Nottingham . . . 164

Anteflexion of the Gravid Uterus. (Dr. GRAILY HEWITT) 170

XXXI. On the Varieties of Form imparted to the Fœtal Head by the Various Modes of Birth. By ROBERT BARNES, M.D. President 171

October 4th, 1865—

Uterus of a Woman who died after Simple Tapping. (Dr. BARNES) 207

Instrument for Introduction of Perforated Laminaria Tent into Cervix Uteri. (Dr. BARNES) . . 207

Presentation of the Original Cephalotribe of Baudelocque to the Society 208

Medicated Pessaries and Suppositories. By Messrs. DUNCAN and FLOCKHART, of Edinburgh. (Suggested by Professor SIMPSON) . . . 208

Preparation of Chloroform for Administration during Labour. (Mr. I. B. BROWN, Jun.) . . 208

XXXII. Case of Twin Pregnancy. By JOHN WAY, M.D. (Communicated by G. C. P. MURRAY, M.D.) . . 209

XXXIII. Case of Vascular (Erectile) Tumour in the Sheath of the Funis in a new-born Infant. By FRED. LAWTON, Esq., of Chiddingfold, Surrey. (Communicated by Dr. BRAXTON HICKS) 210

Microscopical Examination of the Tumour. By Dr. BRAXTON HICKS 213

XXXIV. Abstract of a Paper on Procidentia Uteri, read by J. MARION SIMS, M.D. 213

XXXV. Case of Extreme Distortion of the Pelvis; Craniotomy, Cephalotripsy, Cæsarean Section. By ROBERT GREENHALGH, M.D. 220

November 1st, 1865— PAGE

Announcement of the intended Conversazione in March, for the purpose of exhibiting a full collection of Instruments used in Obstetric Practice . . . 227

Monstrous Fœtus. (Mr. THANE) . . . 227

Voluminous Fibroid Tumour from the Uterus. (Dr. BARNES) 228

Hydatiform Degeneration of the Ovum. (Dr. RUSSELL, of St. Alban's) 228

XXXVI. Case of Ovariotomy in which the Pedicle was Tied and Returned, and the Ligature Removed in Forty-eight Hours. By J. H. AVELING, M.D. . . 229

XXXVII. Difficult Case of Labour connected with a Non-evoluted and Hypertrophied State of the Cervix Uteri. By GEORGE ROPER, Esq., M.R.C.S. . . . 233

XXXVIII. Abstract of a Paper on Procidentia Uteri, read by J. MARION SIMS, M.D. 238

December 6th, 1865—

Fibro-cystic Disease of the Uterus. (Dr. ROUTH) . 253

Polypus weighing two and a quarter pounds. (Dr. B. HICKS) 253

Dermoid Cyst developed in the Fallopian Tube. (Dr. RITCHIE) 254

Growth removed from the Cervix Uteri. (Dr. GREENHALGH) 255

Large Fibrous Polypus. (Dr. GREENHALGH) . . 256

XXXIX. On an Abnormal Variety of the Battledore Placenta. By R. UVEDALE WEST, M.D. . . . 257

XL. Two Cases of Obstructed Labour. With Remarks by Professor BERRY, of Birmingham . . . 261

XLI. On the Comparative Merits of the Cæsarean Operation and Craniotomy in Cases of Extreme Distortion of the Pelvis. By ROBERT GREENHALGH, M.D. . . 270

Index 291

List of Donations to the Library 301

Classified Catalogue of the Library 309

LIST OF PLATES.

		PAGE
I.	Membrane expelled from Uterus (Mr. A. HARRIS)	51
II.	Case of Monstrosity (Dr. A. MEADOWS)	85
III.	Ditto (ditto)	86
IV.*	Case of Hernia Cerebri and Hernia Umbilicalis (Dr. TANNER)	110
V.	Hydatiform degeneration of the Ovum (Dr. RUSSELL)	228
VI.	Abnormal Variety of the Battledore Placenta (Dr. U. WEST)	260

* This Plate is erroneously referred to on pages 109 and 110 as Plate V.

WOODCUTS.

Imperforate Bowel (Dr. MEADOWS) 54

New form of Curette for removal of Uterine Fungoid Granulations (Dr. MARION SIMS) 73

Laceration of the Integument of the Fœtus during delivery (Mr. KING PEIRCE) 74

Section of the Skin in the same case, showing the absence of connective tissue 77

Anencephalic Fœtus (Mr. H. HAILEY) 78

Dysmenorrhœa, Metrorrhagia, Ovaritis and Sterility (Dr. BARNES)—

Figs. 1, 2, 3, 4.—Common forms of the conical vaginal portion of the Uterus 122-3

„ 5, 6.—Cases of coarctation of the os externum uteri . 130

„ 7.—Professor Simpson's Bistouri caché, or Metrotome . 131

„ 8, 9.—Section of the Uterus made on a level with the os internum, anterior aspect 132

„ 10.—Dr. Greenhalgh's modification of the double-bladed Metrotome 133

„ 11.—Dr. Barnes's new Metrotome, cutting scissor-like from without inwards, &c. 135

Diagram showing the different modes of cutting by the Metrotome caché, and by Dr. M. Sims's blunt-pointed knife . 148

PAGE
New Hysterotome, new intra-uterine Spring Tent, &c. (Dr. AVELING) 156
Portable Case of Instruments for operations on the Uterus and Vagina (Messrs. WEISS) 157
Serous Tumour in the Occipital Region (Mr. J. WAITS) . . 159
Case of Twin Monstrosity (Dr. R. ELLIS) . . . 162
Varieties of Form imparted to the Fœtal Head by the various modes of birth (Dr. BARNES)—
Figs. 1 A & B, 2 A & B.—Natural or standard form and size of the fœtal head 175-8
„ 3 A to D, 4 A & B, 5 A & B.—Forms imparted to the head, under turning in contracted pelvis . . 179-185
„ 6 A & B.—A head born after turning, contracted pelvis, and the face having presented . . 186-7
„ 7 A & B.—A head born after craniotomy . 188-9
„ 8 A & B to 14 A & B.—Forms under tedious labour, terminated by the forceps 190-200
Particular description of the above figures . . 203
Vascular Erectile Tumour in the sheath of the Funis in an Infant (Mr. F. LAWTON) 212
Microscopical section of ditto 213
Procidentia uteri, Figs. 1, 2, 3 (Dr. M. SIMS) . . 214-18
Extreme distortion of the Pelvis (Dr. GREENHALGH) . 224-5
Instrument for tying the Pedicle in Ovariotomy (Dr. AVELING) . 230
Difficult case of Labour, seat of the Tumour (Mr. G. ROPER) . 236
Procidentia uteri, Figs. 1 to 8 (Dr. M. SIMS) . 239-47
Tumour of the Cervix Uteri, Figs. 1, 2 (Dr. GREENHALGH) . 256
Contracted Pelvis, in case of Cæsarean operation (Dr. GREENHALGH) 279

ADVERTISEMENT.

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OBSTETRICAL SOCIETY

OF

LONDON.

SESSION 1865.

ANNUAL GENERAL MEETING, JANUARY 4th, 1865.

Dr. OLDHAM, President, in the Chair.

Present—52 Fellows and 8 visitors.

The following gentlemen were elected Fellows:—Mr. J.H. Bridgeman, Dr. E. Copeman, Dr. Fairbank, Mr. Hodder, of Toronto, and Mr. Whitehead.

NOTES OF A CASE OF EXTRA-UTERINE FŒTATION.

By W. S. PLAYFAIR, M.D., M.R.C.P.,
ASSISTANT-PHYSICIAN FOR THE DISEASES OF WOMEN AND CHILDREN TO KING'S COLLEGE HOSPITAL.

THE following case was admitted into King's College Hospital on the 26th of July, 1864, under Dr. Priestley, and subsequently came under my care on that gentleman's departure from town.

Harriet T—, æt. 26, married, the mother of two children. She dates the commencement of her pregnancy from February, 1862. She was perfectly well until the end of April, when she was suddenly seized with severe abdominal pain and frequent faintings. At the end of May—that is, nearly a month after the occurrence of these symptoms—she went into St. George's Hospital, under Dr. Lee, where, according to her own account, she was told that her labour would come on in November. She was discharged, feeling pretty well, after being an in-patient for five weeks; but shortly afterwards the pains returned, accompanied with frequent vomitings. About the time she expected her confinement she began to suffer from a profuse bloody discharge, which lasted thirteen weeks. In February, 1863, she was admitted into the Middlesex Hospital, and while there she lost the discharge, and the pain and sickness from which she suffered were much relieved. Since that time she has remained in her own house, suffering occasionally from pain, but otherwise pretty well. The catamenia have occurred regularly. About a fortnight before her admission she was suddenly seized with severe pain in the back and abdomen, and frequent vomiting. She was unable to take food or to sleep; and this continued until she came into the hospital.

State on admission.—There is considerable emaciation, rapid pulse, furred tongue, and every indication of extreme depression of the vital powers. In the hypogastric region, and extending towards the left side, is a hard and very painful tumour, reaching up to the umbilicus. The surface of the swelling is perfectly smooth, and nothing like fœtal prominences are to be made out. On pressing the abdominal wall downwards it seems to adhere to the surface of the tumour, and then it separates after a moment, communicating a peculiar feeling to the fingers, just as if one was pressing on a mass of putty. The swelling seems more superficial at a point towards the right side, but no fluctuation is perceptible. Per vaginam, the os and cervix are found to be healthy, and the uterus is easily movable, and apparently not enlarged; but the roof of the vagina, chiefly

on the left side, is occupied by a hard, irregular, and immovable swelling. The patient was seen by Mr. Fergusson, who did not think any operative measures justifiable; at a later date, however, it was determined to make an eschar with potassa fusa on the most prominent part of the tumour, with the view of forming an aperture through which the fœtal structures might possibly be extruded. The potassa fusa was applied for the first time on the 9th of August, the slough separating, after several applications, on the 18th. In the mean time, however, the patient got more and more feeble, and she sank on the 1st of September.

On *post-mortem* examination the cyst containing the fœtus was found to occupy the front of the abdominal cavity, being slightly adherent to the internal surface of the peritoneum, especially in the neighbourhood of the eschar, which had not, however, opened the cyst-wall. The rectum and descending colon were attached by very firm and dense adhesions to the posterior surface of the tumour. The Fallopian tubes and ovaries were also involved in adhesions. On the right side they could be made out without difficulty; but only a small portion of the left Fallopian tube could be traced, the remainder, with the ovary of the same side, being lost in the adventitious structures with which they were surrounded. The uterus was of the natural size, and healthy. The cyst itself was thin, smooth on the outside, and of a blackish-gray colour. It contained a yellowish, greasy looking mass, of uniform consistence, in the substance of which portions of the fœtal bones were studded. The greater part of this mass was formed of adipocere, with here and there calcareous patches, and so completely were the fœtal structures transformed that no one of them could be traced. The whole looked like a large mass of soft putty, in which bones had been stuck at intervals. On more minute examination the only recognisable structures were the membranes of the brain, which were found unaltered within the collapsed cranial bones, and contained a small quantity of a diffluent, reddish, and highly fetid pulp, evidently the remains of the brain. All traces of ligamentous structure

had disappeared, the bones were perfectly separated from each other, and were only retained *in situ* by the surrounding mass of adipocere.

This case was probably an example of ovario-tubal fœtation on the left side, the right Fallopian tube and ovary being perfect, the seat of rupture on the left side being undistinguishable from surrounding exudation and adhesion. The history of rupture during the early months of pregnancy is sufficiently plain to negative the supposition of an abdominal fœtation. It is clear, also, that the child lived up to the end of the natural period of gestation, the bones being those of a full-grown fœtus. The curious point is the complete and perfect transformation of the fœtal structures, so that none of them could be made out on the most minute investigation, except the cranial contents, which probably escaped alteration by being shut off from the surrounding parts by the bones of the skull. Such changes, when a fœtus has been long retained in the abdominal cavity, are, as is well known, by no means uncommon, although seldom to the same extent as in this case. I have nowhere seen any suggestion as to the causes of the exceedingly various conditions in which the child is found after death in these cases of misplaced gestation. Sometimes, and perhaps most often, the soft parts are found to be more or less completely altered and destroyed; while occasionally the child is retained in the abdominal cavity, possibly for years, without any change whatever taking place. An interesting example of the latter class is now in the Museum of the College of Surgeons. The fœtus was retained in the abdominal cavity for fifty-two years, and after death its body was found as fresh and unaltered as that of a new-born child. It is difficult to understand how such great differences should be met with under circumstances apparently very similar, and I allude to the subject in the hope that some member of the Society may be able to afford a reasonable explanation.

As regards the treatment of the present case, it is important to decide whether any operative measures would have afforded the patient a chance of recovery. The balance

of evidence is clearly against the performance of gastrotomy until Nature indicates the route she is likely to take in the extrusion of the fœtus, when the aperture formed in the abdominal vessels may be enlarged with comparative safety, and the fœtus so removed. But in this case no aperture had been formed; and independently of this, the patient was in such an exhausted condition that any direct interference seemed contra-indicated. The post-mortem examination only confirmed the wisdom of this conclusion. At a later period it was determined, almost as a last resource, to attempt the formation of an artificial opening by a powerful caustic, in the hope of causing the cyst to adhere to the abdominal wall, and thus to afford an exit for the fœtal structures. The patient, however, was in too exhausted a condition to give this mode of treatment a fair trial, although I believe it might have proved successful had it been resorted to at an earlier stage in the progress of the case.

Dr. PRIESTLEY said that the patient whose case had been described by Dr. Playfair had been under his care on two separate occasions. Some two years ago she was in his ward in the Middlesex Hospital, and the tumour she then suffered from had been diagnosed as an extra-uterine fœtation, but was not then giving rise to urgent symptoms. There were, he thought, two points of much interest in connection with the case. The first had reference to the original position of the fœtus in the early weeks of pregnancy, and its supposed subsequent escape into the peritoneal cavity. It had been suggested that it might be one of the forms of tubo-ovarian gestation; but, on the other hand, the patient had been examined by Dr. Lee, in St. George's Hospital, during the early weeks of pregnancy, and he had not suggested a doubt as to the normal position of the fœtus *in utero*, and had named a time when the woman might expect to be delivered. After this there were all the symptoms of a rupture having taken place, the patient having been collapsed, suffering from peritonitis, and being seriously ill in bed for a considerable period. Was it possible, therefore, that the fœtus had been originally in the uterus, and that rupture of the uterine walls had been produced by accident, causing the escape of the child into the peritoneal cavity, without terminating in the speedy death of the mother? The second point

of interest was in reference to the treatment, and as to the propriety of performing gastrotomy in such cases. The President had incidentally raised a doubt as to the expediency, in some instances of rupture of the uterus, of following the fœtus when it had escaped into the cavity of the belly, and thus increasing the already very serious injuries by attempts to deliver, suggesting as an alternative proceeding the leaving the fœtus until it became encysted by adhesions, and then removing it by incision through the abdominal walls. He (Dr. Priestley) was of opinion that gastrotomy would have been quite justifiable in the case described, when urgent symptoms began to declare themselves; but when the poor patient was admitted to King's College ward symptoms of blood poisoning were fully developed, and her strength was so far exhausted that it was deemed inexpedient to operate. It was decided, therefore, to endeavour to make an artificial opening by potassa fusa, in the hope of thus gluing the abdominal walls to the surface of the cyst, and then evacuating its contents. Unfortunately the patient sank before this could be accomplished.

DOUBLE MONSTROSITY, WITH ACCOUNT OF THE DELIVERY.

By W. Wills, Esq., Totnes, Devon.

(Communicated by Dr. Graily Hewitt.)

In the absence of Mr. Owen, Mr. Wills visited a patient, P—, a spare, thin woman, æt. 21, in labour with her first child. He found one foot protruding, and immediately another, of unequal size. On comparing them it was found that they were two left feet. On further examination the foot of a right leg was found corresponding to the first, and another foot much higher up. On making extension of the *pair* for the purpose of delivery the second left foot receded, the breech descended to the outlet, but could be brought no further. Mr. Wills imagined that he had to do with a monster, but of what kind could not distinctly determine. At half-past one—three hours and a half after Mr. Wills's first visit—Mr. Owen came to his

assistance, and, as the child first in advance was dead, it was determined to deliver, Mr. Wills still holding the opinion that the two feet, now to be felt only at the mouth of the uterus, belonged to the same child, and that the junction was at the shoulders, or that there was one large head—a specimen of which kind may be seen in the College of Surgeons' Museum. The delivery was accomplished in the following manner, under chloroform. Mr. Owen extracting by bringing down the presenting legs, and drawing backwards; Mr. Wills introducing the left hand, finding the mouth, introducing a blunt hook with the right, and thus bringing down the chin, and shortly after the head, when an abdominal attachment became manifest. The other and rather lesser child was then easily made to follow by laying hold of the other feet. The woman was remarkably well the next day, and continued to make complete recovery.

The dissection.—The children were well formed, with the exception of their junction, one a little larger than the other, both males. Their union was by bone, cartilage, and skin, with integuments, placed direct face to face; the sternal extremities (ensiform cartilages wanting) were firmly attached by the bones and cartilages, of four or five ribs on each side, for about seven inches in all; the skin and integuments of the belly expanded to form one abdominal cavity down to the umbilicus; the cord, double and in one sheath, entered the abdomen underneath and between the two children; the liver (one large mass) lay between the two, on the right side of the larger one and the left of the other, with one gall-bladder, from which issued two common ducts. There was one large spleen; the intestines were perfect and distinct in their course for each child; all the other viscera thoracic and abdominal, were in duplicate and perfect.

Mr. Wills expressed his opinion that, with assistance earlier, they might have been brought alive into the world by making the other two feet follow the first, *pari passu*, a little after, so that the heads might have followed each other. Would such a step be justifiable, with proper regard

to the safety of the mother? Such a state of existence, too, however interesting it might have been to others, would, he thought, have been an awkward one for the parties concerned.

In the 'London Medical Journal' for January to June, 1824,[1] there is a case reported, where Mr. Wills assisted at the investigation of the internal arrangements of a double male child or children, of about the same size, and also come to perfection. In that case there was but one heart, the intestines reached below the stomach, and again separated into two distinct channels. Mr. Wills's name is misspelt therein as *Mills*.

CASE OF EMBOLISM OF THE PULMONARY ARTERY AFTER OVARIOTOMY.

By E. Parson, M.D. Lond.

The specimen I now show will illustrate fibrinous deposition in both cavities of the right side of the heart. The deposit is seen to be firmly adherent to the greater part of the wall of the right auricle, and particularly so in the auricular appendage, where the deposit seems to have begun; for here the clot almost fills that portion of the auricle, and is accurately moulded to the little muscular eminences. The clot is seen to be continued through the tricuspid valve into the right ventricle, and where it passes through this opening almost filling it; in the right ventricle it is found to be intricately interlaced with the chordæ tendinæ, it being impossible to separate their mechanical adhesions to the columnæ carneæ. As the clot extended along the pulmonary artery to the lungs, it was found to be *tubular*, and adherent to one of the semilunar

[1] Toms, W., Esq., Kingsbridge, "Case of Male Twins," p. 292, January to June, vol. li.

valves of the pulmonary artery; I therefore concluded that the clot was *ante-mortem*, and materially assisted in shortening the life of the patient.

The following is a short history of the case:

A young woman, æt. about 20, underwent ovariotomy in the Samaritan Hospital, by Mr. Spencer Wells, on December 14th, 1864. She had been moderately healthy before, and the operation was quickly and easily performed, the cyst being almost unilocular, the wound in the parietes being the usual short one, such as Mr. Wells usually practises in cases of simple cyst. The pedicle was long and thin, and easily secured, as usual, by an ordinary clamp. She recovered very well from the chloroform, and remained comparatively well during the first twenty hours after the operation. About this time the pulse rose to 120, the tongue became unusually loaded, and she became also very thirsty —much more so than ovariotomy cases generally are.

On the second day the pulse rose to 140; she complained of scarcely any pain, vomited, and there was a peculiar look of oppression in the countenance.

On the third day this oppression greatly increased; the pulse 140 to 150; the urine albuminous and scanty; heart sounds indistinct and muffled, and a peculiar dusky hue about the face; the abdomen a little tympanitic; and it seemed evident that death would result, and that fibrine was clotting in the heart (which in a former case was not relieved by any treatment, including ammonia); and as it is often found that oppression is much relieved by the appearance of the menses or bleeding from the arm, Mr. Wells determined to bleed to five ounces from the arm, and to give dilute hydrochloric acid every two hours. The blood was very dark, and rather thicker than usual, but was not markedly buffed afterwards.

On the fourth day she became still more oppressed, and very restless; vomiting continued; a great difficulty in keeping her warm, the surface of the body becoming white and cold; and she died at 11 a.m. on the 18th December, 1864.

On *post-mortem* examination the abdominal wound was found not to have united, and looked sloughy on its peritoneal aspect. There was diffuse inflammation of the peritoneum, of the low form, attended with a few ounces of sero-purulent fluid in its cavity; but little lymph found anywhere. The pedicle found to have been well secured. The heart was normal, except the fibrinous deposits and some blackish blood in the right side; the left side empty.

I beg to suggest the following as the probable train of events in the case. First, the low form of peritonitis setting in after the operation, which generated some poison, which got absorbed into the general circulation, and that this caused, on the first and second days, the intense thirst and loading of the tongue. That on the second day the peculiar oppression, faltering pulse, and feeble heart sounds, indicated fibrinous deposit commencing in the heart, which was better shown on the third day. I beg to remark how utterly hopeless are those cases, and how painful it is to have to look on whilst the separation of fibrine from the blood is killing the patient by filling the right heart; and further remark that she died so slowly because that portion of the clot in the pulmonary artery was hollow, and allowed the blood for a time to get into the lungs; and which contrasted with a former case in the Samaritan Hospital, where the patient died more rapidly, and became blue, and almost livid, before death; that this case now presented might have been diagnosed to have been a *tubular* clot, from the absence of blueness and the slowness of death; and lastly, if now those who have helped us to the pathology and diagnosis of those cases could inform the Fellows of this Society how to *prevent* those deposits, or how to remove them when deposited, they would confer a lasting boon on us as obstetricians and those who are called upon to treat the diseases of women.

Mr. Spencer Wells said he believed the peritonitis in this case to have been septic—due to the hospital atmosphere, which at this time was injuriously affected by two other patients suffering from erysipelas and pyæmic fever. His chief object in

the bleeding was to give mechanical relief to the heart, and lessen congestion of the kidneys. Relief to the breathing was afforded, and the urine became more abundant after the bleeding, and was less loaded with albumen.

Dr. RICHARDSON said he regretted that Dr. Parson, in his able report of the case, had used the word "embolism;" he regretted this because the fibrous generation in the heart that was before the Society was, in truth, not an embolus, according to the strict use of that term; and he regretted it also because the term ought never to be used at all. "Embolism" and "thrombosism" were, in fact, absurd words, and they were doing great harm, for they led the mind away from the pathological fact to mere terms that had no meaning at the best, and that were constantly misconstrued. At the same time he (Dr. Richardson) was very happy to see the subject of fibrous deposition receiving at last the attention it deserved. When, fifteen years ago, he revived this question (for, in truth, the question is only a revival of the labours of Chisholm, Gould, and other writers of the two preceding centuries), he was considered as putting forth false notions in pathology, and it was boldly averred that these concretions were always found *after* death. Now a more correct knowledge prevailed. Dr. Richardson then spoke in reference to the concretion itself, which he said was one of the finest specimens he had seen of a tubular concretion; such a concretion would give rise to a very slow death, extending over two or three days. He next described the symptoms of concretion in the right side of the heart, and stated the diagnosis to be so plain that the precise position of the clot in the cavity could be determined before death. Regarding the cause of deposition, the view he had formerly held, that these concretions were not produced by the introduction of septic poisons, but were of inflammatory origin, must be modified. He had learnt by experiment that fibrine might separate in the blood, not only in consequence of a direct increase of it, but by introducing with the mass of blood decomposing substances. Great obscurity, however, still surrounded the inquiry, for the same poison that in one experiment would render the blood of an animal universally fluid would in another experiment lead to deposition of fibrine. He could attribute this fact but to one circumstance, viz., that the condition of the air, the meteorological condition at the time of infection, was the determining cause of the course of degeneration of blood that would ensue. At present, in cases of ovariotomy where there was absorption of morbid matter the patients died, either from ammoniacal degeneration of the blood or from separation of fibrine; but why this distinction should exist remains to be shown. Treatment, when signs of concretion were presented, is most difficult; we might try to dissolve the concretion by alkalies; but unfortunately all the

alkalies dissolved also the blood-corpuscles, and in a clear case of concretion where he had pushed the alkalies to the extent of affecting the concretion this event had happened. Some years ago he had put the question forward, whether a concretion could be *mechanically* removed from the heart by the veins. In one case, where a concretion had been artificially induced in a cat, he had actually removed it from the right heart by a crotchet needle passed down the innominate vein, as he had thought that *in extremis* something like this might be done in the human subject, or that the concretion, if not removed, might be broken up; but even if these objects could be effected there would be danger that the concretion would re-form, as the conditions that gave rise to the deposit would remain. The remedy really to be looked for was a substance that would rapidly dissolve fibrine, and would leave the blood-corpuscles intact; such a remedy injected into the veins might probably prove of service, but its discovery almost implied a paradox. One point of practice, however, was open to those who performed such operations as ovariotomy, and he (Dr. Richardson) would very respectfully point it out for the first time. It was that the surgeon should begin to inquire whether the external influences of heat, humidity, barometric pressure, and ozone, did or did not affect the results of operations. He would recommend that the exact meteorological conditions shortly before and shortly after days of operation should be kept, and it should be noted what periods were most favorable to recovery and what most unfavorable. As these were cases that could wait for the proper period, it was possible the fatality might be lessened by a knowledge thus obtained by the operator when to perform and when not to perform the operation.

AMPUTATION OF THE ARM IN PREGNANCY.

By Albert Napper, Esq.,
SURGEON TO CRANLEY VILLAGE HOSPITAL, ETC.

The following case, though in its main features possessed of no unusual character, the author thinks may be worthy of record, inasmuch as the performance of a capital operation on a woman far advanced in pregnancy is of rare occurrence, and never likely to be resorted to except under urgent and pressing necessity. The patient was a tall, fair, delicate-

looking young woman, æt. 23, married, and pregnant with her first child. On April 14th, 1864, she was admitted into the Cranley Village Hospital, with strumous swelling of the right elbow. Eschars of old date on the neck and other parts clearly indicated a cachectic diathesis. Her general health was beginning to suffer, and hectic symptoms had begun to appear. The skin as yet had not ulcerated, but disorganization was progressing within the joint. At the beginning of May a probe could be passed freely into the joint. By the 10th it passed through it to an opening on the opposite side. The pain was very great, and the discharge profuse. On the 20th her sufferings had become very intense, her nights sleepless, and the disease, which was of a purely scrofulous character, was extending from the elbow up the internal condyle of the humerus. If any remedial measure was to be resorted to, it was now clear no time was to be lost; and as she had just completed her seventh month of pregnancy, I determined on the removal of the limb, which was readily assented to by herself, as also her friends. On the 25th, having placed her under chloroform, assisted by some medical friends from Guildford, I amputated the arm about the middle of the humerus, the patient remaining quite unconscious until the operation was completed. Her subsequent progress was most favorable. The stump healed well; her appetite returned, and she quickly recovered her usual animated and happy expression of feature. As regards her pregnant condition, she never experienced the slightest inconvenience from the operation, either at the time or subsequently. The after-dressings produced no unusual distress, but from the time of the removal of the source of her sufferings she became calm and quiet, and quickly regained her usual rest. By the 6th of June she had so far recovered as to get down stairs, and on the following day was walking in the garden. By the 22nd the stump had healed, but she had been complaining for some days of pain and tenderness of the knee, which was subdued by the application of a stimulating liniment. She had also for some time had a strumous swelling over the left

external malleolus, which now appeared disposed to suppurate. On the 27th this broke, and discharged thick pus. On the 29th, her general state of health being good, she was discharged. Early in the morning of July 3rd she was taken in labour, and in less than three hours afterwards gave birth to a female child, the labour being in all respects of an ordinary character. The strumous ulceration of the ankle increased until the limb assumed a very unpromising aspect, but terminated in a slough being thrown off and its resuming its natural condition, fortunately without implicating the joint.

I had an opportunity of seeing her some months afterwards. She had lost the child, but was in good health herself, and able to perform all her household duties with her one arm.

After the Ordinary Meeting, the business of the Annual Meeting then commenced.

The report of the Auditors of the accounts of the Treasurer for the year ending December 31st, 1864, was read, from which it appeared that the balance in the hands of the Treasurer is £262 6*s*. 5*d*., and that during the year a sum of £181 10*s*. was invested in Consols in the name of the Trustees of the Society, making a total now invested in Consols of £731 10*s*. The balance-sheet showed that the Society had received during the year the sum of £469 7*s*. as subscriptions from the Fellows, and £40 9*s*. 6*d*. from the sale of 'Transactions.'

Mr. Mitchell, in proposing the adoption of the report, congratulated the Society on its financial prosperity.

Mr. Nichols having seconded the resolution, it was carried unanimously.

The Secretary read the following alterations of the laws, rendered necessary by the opening of the Library.

Proposed Alterations and Additions in the Laws.

CHAP. I, SEC. IV.—*Insert the words* "an Honorary Librarian" *after the word* "Treasurer."

CHAP. VI, Sec. II.—*Insert the words* "and Librarian" *after the word* "Secretaries."

Three new Chapters of Laws to be enacted as follows:

CHAPTER X.—OF THE HONORARY LIBRARIAN.

1.—The Honorary Librarian shall have the superintendence of all matters relative to the Library.

2.—He shall make a report to the Society at the Annual Meeting as to the general state of the Library, and shall refer to the Council any recommendations made by the Fellows for the purchase of new works.

3.—He shall see that the titles of all works presented to or purchased by the Society are duly entered in the catalogue; also that all the books, plates, tables, &c., in the Library, are stamped with the Society's stamp or die.

CHAPTER XI.—OF THE LIBRARIAN.

1.—He shall be appointed by the Council. He shall give out the books to the Fellows according to the directions of the Council, be subject to such rules or orders as the Council may deem necessary, and receive such remuneration for his services as they shall appoint.

CHAPTER XII.—OF THE LIBRARY.

1.—The Library shall be under the management and direction of the Council. It shall be open every day (Sundays excepted), at such hours as the Council shall appoint.

2.—Four books shall be allowed to be in the possession of a Fellow at the same time.

3.—Periodical publications shall remain on the Library

table for the inspection of Fellows for a month, and other books for a week, after they are received.

4.—When a book is wanted which has been in the possession of a Fellow a fortnight, the Librarian shall send a notice by the post to the person in whose possession it may be, requesting the return of it; and a fine of sixpence shall be incurred for every day that it may be detained after the third from the transmission of such notice; and until the return of such work or works, and the discharge of all fines incurred through delay, no further issue of books shall be permitted to the Fellow so applied to.

5.—Every Fellow shall enter in a book kept for that purpose in the Library the titles of any books borrowed by him, and affix his signature thereto, which shall be countersigned by the Librarian. In the case of Fellows resident more than four miles from the Library, they shall make written application for any works they may require, and shall pay all cost incurred in the transmission of books from or to the Library.

6.—All books shall be ordered in for inspection at such times as the Council shall appoint, being not less than once in the year, and a fine of five shillings per volume shall be incurred for neglecting to send in books by the time required in the notice.

7.—A book shall lie on the Library table, in which Fellows may insert, for the consideration of the Council, the titles of such works as they may wish to be purchased by the Society.

8.—Fellows who borrow books from the Library shall be answerable for the full value of any that may be lost or injured.

9.—The Council shall have it in their power to collect the fines in the way which they may think best.

The Chapters at present numbered X, XI, XII, XIII, XIV, and XV, *to be designated respectively as Chapters* XIII, XIV, XV, XVI, XVII, and XVIII.

The adoption of these, being proposed by Dr. MEADOWS,

and seconded by Dr. HALL DAVIS, was unanimously assented to.

It was then announced that arrangements were now completed for lending of the books of the Library to the Fellows, at Mr. Hardwicke's, Publisher, 192, Piccadilly.

Dr. PRIESTLEY, in proposing thanks to the officers of the Society, said that an agreeable duty devolved upon him, mingled with some regrets. It seemed that in all mundane affairs men who had been actively engaged in them must pass away, and successors be appointed. While, therefore, the Society welcomed Dr. Barnes as its new President, it had to regret the loss of Dr. Oldham in that capacity. It was quite unnecessary to pass any eulogium on Dr. Oldham; his name was most familiar to all who knew anything of obstetric science, and the Fellows knew how ably he had fulfilled the duties assigned to him as President. The Society had undoubtedly reaped great benefit by having the advantage of Dr. Oldham's great experience and judgment to direct its proceedings, and he believed Dr. Oldham would feel that some lustre was reflected on himself when he was elected to so distinguished a position, and that he would look proudly back on the year when he was President of the Obstetrical Society of London. Dr. Hewitt also this year retired from the office of Secretary, and was succeeded by Dr. Meadows, who would, no doubt, prove a most worthy successor. Dr. Graily Hewitt had laboured hard from the very foundation of the Society to advance its interests, and only those who had served on the Council when it was first constituted knew how unceasing and valuable had been his services. He proposed, therefore, "That the best thanks of the Society be and are hereby given to the President and Officers of the Society for their services during the past year; and that the especial thanks of the Society be given to the retiring President, Dr. Oldham; and to the retiring Hon. Secretary, Dr. Graily Hewitt, for the able and efficient manner in which he has rendered assistance from the commencement of the Society."

Dr. GREENHALGH rose with much pleasure to second the

vote of thanks to the retiring President for the efficient manner in which he had discharged the important duties of his office. So much had been said, and deservedly so, by previous speakers about the ability and zeal of the ex-President, that little room was left for further comments; he could not, however, allow this opportunity to pass without noticing what every one must have remarked, that they had been presided over by a gentleman who, while professing a profound respect for the past, looked forward hopefully to great improvements, and many important modifications of opinion and practice for the future, which were clearly indicated in his able, much interesting, but too short address, and of which he had set more than one excellent example. Dr. Greenhalgh concluded by stating that not least among his many excellencies were his kind, courteous, and sociable qualities; thus, while supporting the dignity of his office, he felt confident he (Dr. Oldham) had secured by word and deed the kindly feeling and esteem of every one; he had, therefore, no doubt that the vote of thanks would receive the cordial support of every Fellow of the Society, and especially of all those present that evening.

Dr. Oldham and Dr. Graily Hewitt answered in acknowledgment.

The list of donations to the library was then read.

The following gentlemen were then elected Officers for the ensuing year:—

Honorary President.—Sir Charles Locock, Bart., M.D., F.R.S.

President.—Dr. Robert Barnes.

Vice-Presidents.—Dr. Gream, Dr. Greenhalgh, Mr. F. S. Haden, Mr. Robert Hardy (Hull), Dr. Tanner, Dr. J. G. Wilson (Glasgow).

Treasurer.—Dr. Graily Hewitt.

Honorary Secretaries.—Dr. J. Braxton Hicks, F.R.S., and Dr. Alfred Meadows.

Honorary Librarian.—Dr. Alfred Meadows.

Other Members of Council.—Dr. Aveling (Sheffield), Dr. Clay (Manchester), Dr. John Hall Davis, Dr. Gervis, Dr.

Alfred Hall (Brighton), Mr. I. Harrinson (Reading), Dr. Madge, Mr. Josh. T. Mitchell, Dr. Gustavus C. P. Murray, Mr. Edward Newton, Dr. Oldham, Dr. W. O. Priestley, Dr. Edward Ray, Dr. Samuel Richards, Dr. Thomas Skinner (Liverpool), Dr. Tyler Smith, Mr. Fred. Symonds (Oxford), Mr. James Reeves Traer.

The PRESIDENT then delivered the annual address.

ANNUAL ADDRESS

DELIVERED BY THE PRESIDENT,

HENRY OLDHAM, M.D., F.R.C.P.

GENTLEMEN,—The subject of the President's annual address is, if I rightly understand it, necessarily limited. It is neither an oration nor a digest of the papers which have been read before the Society. There is certainly nothing so inviting in the literature of medical orators as to induce us to add another to the series; and our Transactions and published Reports would render the latter superfluous. But the expected subject of the address is the Society—a report to the Fellows of its state, its progress, how it has worked, and the changes which have transpired during the past year. Bearing this in mind, I am happy to say that I shall detain the Society only a few minutes, as the details which it will be my duty to lay before them recount nothing but what is favorable and advancing, and need neither explanation nor apology.

The total number of Fellows is now 512, and of these 43 have been elected during the past year, and amongst them some from Australia, one from New Zealand, and one from Madras. Three new Honorary Fellows have been recently elected from amongst distinguished foreign obstetricians, viz., Professor Pajot, of Paris, Professor Hecker, of Munich, and Dr. Marion Sims.

You will be glad to know that one main element of the stability of the Society, our Funds, have increased. Last year our property in the funds was 550*l.*, and it is now 731*l.* 10*s.*, 180*l.* 10*s.* having been invested this year; and there is now 262*l.* 6*s.* 5*d.* as a balance at the bank. The formation of a library, by which the book property of the Society might be safely disposed and made conveniently accessible to the Fellows, has long engaged the attention of the Council; and I have now to announce to you that an agreement for two years has been made with Mr. Hardwicke, 192, Piccadilly, at a rent of 40*l.* a year, by which any Fellow of the Society may obtain and take home with him four books, and inspect periodical publications, subject to the resolutions which have been printed and circulated amongst the Fellows. It is intended to purchase such works as the Fellows of the Society are likely to want as they come out. The number of books now possessed by the Society exceeds 1000; they have been the gifts of Fellows. During the past year there have been several accessions; and I would now invite the Fellows to contribute what works they can to the formation of a really valuable library on midwifery and the diseases of women and children. We have to lament the deaths of six Fellows during the past year, all of whom, I believe, were in general practice, viz., W. Cumpstone, Market Raisin, Robert G. Powell, Buntingford, G. Reece, Sussex Gardens, G. Simpson, Bedford Place, Old Kent Road, Henry Wilkin, and P. R. Wakeman, of Crickhowell.

I feel assured that the Fellows will regard this report as affirming the prosperity of the Society and its unhalting progress. Nor is there less cause for congratulation on the quality of our Transactions, or the tone and temper of our discussions. It is hardly necessary to do more than refer to the former; but I confess that the only shade of misgiving I had, when first assuming the office of President, had respect to the latter. The truth is, my experience of discussions on disputed points of practice in midwifery and the diseaes, of women in other societies before our own was established had taught me that they were calculated to elicit

very earnest, not to say passionate expressions, in the tumult of which the discernment of science was imperilled, and a society stricken with division and discord. I am disposed to believe that our branch of the profession more than others engages in questions in which feeling may colour our speech, and, unless restrained, surprise it into impetuosity. But although during the past two years subjects have been discussed on which there has been a strong diversity of opinion, yet on no occasion whatever has the authority of the President been exercised to moderate, far less to control the discussion. It will be to the interest of the Society to maintain this tone unimpaired; and if during this next session topics are introduced which excite interest, not only in us but in the great mass of the profession, we should be cautious, however strong our individual opinions may be, not to prefer them in the spirit of an indictment. Our Society has achieved great success; its influence, both in this country and abroad, is considerable; and it concerns us much, when as a body we may be said to speak, that it should be with the authority which springs from caution, discernment, and a fearless spirit. It has often struck me that it would be desirable, when any new point of practice is advocated—in itself of great moment and interest—that two experts from the Society, with the sanction and co-operation of the author, should watch and report upon it. Some three years since I ventured to make a suggestion in reference to the operation which was proposed for the radical cure of fibroid tumours by removing a portion of them. Considering the frequency of these growths, there was no subject of greater importance; and I am sure of this, that an intelligent and independent report, or a few hospital cases, would have been a great boon, especially to those of us who, like myself, could not see their way to adopt it. Very recently a tumour was exhibited, which was described as a solid ovarian tumour, removed by operation. It struck me, as I cursorily examined it, that it was a fibro-cystic tumour of the uterus. Two Fellows of the Society agreed to report upon it, and confirmed its ovarian origin. The momentous issue to the

welfare of women evidently bears no comparison between the two. Why not engage the same co-operative skill and industry in both? For my own part, I believe that this plan, fairly undertaken and carried out, would be of value to the profession, honorable and useful to the operator or author, and creditable to the Society.

The contributions to the Society have rarely been more useful than when dealing with subjects which have had the fixedness of tradition. It was a bold innovation on the part of one of our Honorary Secretaries to question the advantage of supporting the perinæum in the second stage of labour. This time last year I ventured to disturb some of the time-worn precepts for the management of the puerperal state, every one of which will bear reconstruction; and, indeed, it may generally be said that a revision of old questions by the aid of new discoveries will often end in some practical modification of them. There are several such subjects which we may hope to have before us; but no one, perhaps, more demanding a careful and ample treatment than the influence of ergot of rye upon the mother and child in parturition, and as a uterine excitant in some of the functional and organic diseases of the uterus. I am tempted also to advert to another subject, which affects us more, perhaps, as obstetric practitioners than in our corporate capacity. I refer to nurses for the lying-in room and for the diseases of women. I forbear to indulge in the merriment of describing the traditionary monthly nurse; but we yet find common enough the old characteristics of a former fertility, with its concomitant experiences; and, as a preliminary to the office, a worn-out body and half-drivelling mind. But, in truth, we are behind the medical and surgical branches of the profession in the prevailing quality of these assistants. Several well-conducted and flourishing institutions have sprung up to their aid, while we depend almost exclusively upon ourselves, and have our individual following. This may answer very well for some of us; but it is notoriously insufficient as regards the great body of practitioners and the greater wants of patients. The amount of misery and injury which

is inflicted on lying-in women by ignorant nurses is deplorable, and may well stir the sympathy of us all. The time is now ripe for us to strive for something better, and to encourage institutions like those to which I have referred. The pursuit itself is too congenial to a woman's nature to fail to be attractive, and I do not think it would be long, were access to it made clear and easy, before a superior class of women would select it as a vocation and for a livelihood. I do not doubt that if from the first candidates were placed under the discipline of a well-ordered institution—that age, health, fitness, and respectability were carefully tested—that they were efficiently trained at the public hospitals—that a fixed remuneration was assured to them—that such an institution would not only be a success, but that nurses so prepared would be a vast protection and comfort to a large class of lying-in women; that they would be of great use to the profession—that obstetric practice would be improved by them, and the obstetric practitioner released from an anomalous, and too frequently a humiliating influence. What, too, can be more absurd, as a traditional custom, which still lingers in the land, than to summon a jury of matrons to determine on the existence of pregnancy as a bar to execution? The Society might, I think very well, on the first opportunity, endeavour to move the legislature to alter this, and refer such cases for the future to obstetric practitioners. But I should exceed the limits which I have assigned to a President's address were I to comment on more of the many subjects which come before me.

Let me only, therefore, when on the eve of vacating the honorable office which for two years I have held in this Society, express my warm acknowledgments to the two Honorary Secretaries for their readiness on all occasions to direct and assist me by their greater experience of the detailed working of the Society. What measure of success has attended the Presidency has been far more from them than from myself; and, indeed, there is no better security for the prosperity of a society like ours than that it should be able to enlist the zealous services of men so accomplished

and distinguished as themselves. And I would also offer my respects to the Fellows of the Society for their consideration and support, which have not only relieved the performance of my duties from anything like irksomeness, but has rendered it one of the most agreeable and instructive recreations of my professional life.

A vote of thanks was proposed by Dr. TYLER SMITH, and seconded by Dr. GREENHALGH, to the President for his excellent Address, which was carried unanimously.

FEBRUARY 1ST, 1865.

Dr. BARNES, President, in the Chair.

Present—37 Fellows and 6 visitors.

The following gentlemen were elected Fellows of the Society:—Dr. Carrells, Sussex Street, Warwick Square; Dr. Trend, Southgate Road, Islington.

DR. GREENHALGH exhibited a polypus weighing about 1 lb. 9¼ oz., which he had removed five hours ago from a woman æt. 40, married ten years, never pregnant.

About six months after marriage she first perceived a small lump, the size of a hazel-nut, internally, in the left iliac fossa, which continued about the same size until five years ago, when it began to enlarge. Two and a half years ago she began to suffer from pains of a paroxysmal character in the lower abdomen, followed in six months by a sanguineous, watery discharge, which has continued more or less up to the present time. Becoming very weak, she sought advice at one of the metropolitan hospitals, where the nature of her affection was diagnosed. She was advised not to undergo any operation, but to go to a convalescent establishment. She became, however, so much worse from repeated and severe floodings, that she sought Dr. Greenhalgh's advice, who deemed it imperatively necessary, notwithstanding her very anæmic and prostrate

state, to remove the growth without delay. She was put under chloroform; the polypus was seized with a pair of strong vulsellum forceps, and was, owing to its large and expanded form, divided in its anterior third, which, on being pulled through the external orifice of the vagina, enabled Dr. Greenhalgh to reach a large and firm pedicle, which was cut through by a strong pair of curved scissors. There was a little bleeding during and none after the operation. Dr. Greenhalgh, in some remarks upon this case, laid great stress upon the desirability of cutting away these growths, and upon the far greater safety of removing them *in situ* to making forcible traction upon the uterus to bring them within easy reach of the operator.

Dr. Bathurst Woodman showed a specimen of numerous fibroid tumours in a uterus belonging to one of the victims of the so-called "Mile End Tragedy," (where two women were found dead, and no adequate cause could be assigned, except a suspicion of poisoning.) The woman was about forty years old, married, and of loose character, she had never had any children. Some of the tumours, of which there were about fifteen altogether, were internal, some in the walls of the uterus, and some growing out of them into the peritoneal cavity. The os uteri was exceedingly small and circular.

He considered the specimen interesting, as regards the connection between unfruitful sexual excitement and fibroid growths.

CASE OF CHANCRE ON OS UTERI.

Reported by Dr. W. Bathurst Woodman.

Anne J—, æt. 21, a rigger's wife, residing at Stepney, whose first child was born in September last, came under the care of Mr. Timothy Richardson, surgeon, the last week in

November. She then had ulcers on both tonsils, and some soreness at the back of the tongue. The tonsils and soft palate were much congested, and there was great anæmia. Mr. Richardson suspected syphilis; but the woman had no nodes; and had never had any rash. There were no signs of syphilis on the external genitals. She had no leucorrhœa; and the child, whom she was still suckling, showed none of the signs of congenital syphilis. (The husband denied stoutly all primary and secondary symptoms.) He thought it best to treat the throat affection locally, and to give tonics and stimulants. The ulcers, however, soon assumed a phagedænic aspect, and she became so much worse that Mr. Richardson strongly urged her removal to the London Hospital after three weeks. She came there on the 14th December. There were then deep ragged excavations on both tonsils, especially the right, involving the pharynx, and part of the soft palate, especially the lower ends of the pillars, and about half the tongue (posteriorly). She was much depressed, and was therefore ordered to wean the infant, which, however, was seen by me, and certainly had no evident signs of syphilis. The woman, however, exhibited, in a marked degree, the "dirty-looking anæmia," or "washed-out" look of syphilitic cachexia. Still, some doubt rested on the diagnosis. She was given iodide of potassium and steel, and perchloride of iron to the sores on the tonsils, &c., with a liberal dietary. At first she improved, and the right tonsil, which had bled at first rather profusely, began to stop sloughing, and to granulate healthily. But towards the beginning of January she began to refuse food, had slight cough, and a little diarrhœa. On the 10th January, after a little exacerbation of diarrhœa and severe abdominal pain, she died rather suddenly on sitting up in bed.

Post-mortem examination.—Brain anæmic; no special diseased conditions besides.

About 4 oz. pale clear serum in pericardium; no injection of pericardium, or lymph. Heart nearly empty; right side quite so; slight thickening of the mitral

valves. Both tonsils, and the posterior half of the tongue, and base of epiglottis had been destroyed by the ulceration. The larynx was almost intact. The lungs were anæmic and a little emphysematous, the bronchi slightly reddened. The liver, spleen, and stomach, appeared fairly healthy, although unusually bloodless. The kidneys were rather granular. But *on the posterior* lip of the *os uteri*, and partly involving its right commissure, was a sore, with clean-cut edges, rather larger than and nearly the same shape as a horse-bean; its base slightly thickened, and so elevated above the surrounding parts; its floor worm-eaten, covered with a thin scanty discharge, and had adhering to it an ashy tenacious slough. The *anterior* wall of the vagina, which lay in contact with it, had a sore of almost exact identity of shape and appearance, but without any induration. The uterus had quite regained its normal size (less than four months after labour), and otherwise appeared healthy. No trace of any present or past sore on the external genitals. The specimen, when quite fresh, was seen by Drs. Robert Barnes, Andrew Clark, and N. Parker; also by Mr. Hutchinson and others, who all agreed as to its specific nature.

The husband admitted, after his wife's death, having had sores "a long time ago," and "a running" much more recently.

ON A NEW METHOD OF SECURING THE PEDICLE IN OVARIOTOMY.

By I. B. Brown, Esq., F.R.C.S.

The author observed that hitherto there had been three distinct methods of securing the pedicle—first, by ligature, allowing the ends to hang out, as practised by Dr. Clay, of Manchester (the pioneer of ovariotomy in this country, who had steadily led us on to our present successful results),

and by Lane (the first surgeon in London who performed this operation) secondly, by clamp, as first suggested by Hutchinson, and followed by many others; thirdly, by cutting off the ligature short and closing the wound, as first successfully practised by Rogers, of New York, in 1829, by Dr. Bellinger, in America, in 1835, by Dr. Siebold, of Darmstadt, in 1846, and recently by Dr. Tyler Smith. The first three gentlemen's cases were all successful, and the last-named gentleman has also had great success. Mr. Brown said that his objections to the first method had been the length of time required for the ligature to come away, which varied from nine days in his own practice to a month in that of others; to the second, the frequent severe pain caused by the dragging of the pedicle or the pressure of the clamp itself; to the third, the unsuccessful results in his hands following its use. Having repeatedly used the actual cautery of late, employing Dr. Clay's instruments, in burning adhesions off the omentum and elsewhere, he had been gradually led to the conclusion that the actual cautery might be employed in treating the pedicle itself. Consequently, on December 28th, 1864, he tried it upon a patient of Dr. Burchell, of the Kingsland Road, a lady forty-seven years of age, who had had three children, the youngest twenty-one years since. This disease was first discovered by Dr. Burchell in August last, and so rapidly increased as to lead Dr. Barnes and Dr. Tanner to recommend extirpation some short time before he (Mr. Brown) saw her. As the abdomen then was very large, the skin shiny, and the general health rapidly suffering, he performed the operation by Clay's large incision. There were many adhesions laterally and posteriorly, the bleeding from which was checked by the actual cautery; and, finally, the pedicle, being secured by a clamp, whilst a very large multilocular mass of cysts was removed, was thoroughly seared by actual cautery and allowed to drop. The wound was then closed in the usual way, and it healed in a week, the patient being convalescent in a fortnight. Mr. Brown thought that if this plan were found by repetition to be successful, it would

very materially lessen the dangers of the operation, and consequently ensure a greater number of recoveries.

Dr. ROUTH said the manner in which the peritoneum would conduct itself in throwing out lymph over the burnt ends of a pedicle would be answered, even short of larger experience with the latter, by the results observed in the omentum. He had seen Mr. Brown use the red-hot iron in cutting off pieces of omentum with perfect safety to the patient. If Mr. Brown would state the number of times he had done this successfully, those results would be a sufficient answer to Dr. T. Smith as to its advisability.

Dr. PARSON begged to differ from the President, Dr. Barnes, and Mr. Baker Brown, in the assertion that "the clamp was always painful, and in the way," for in a very large number of cases where the clamp has been used, at the Samaritan Hospital, they have frequently had scarcely any pain or inconvenience; and it often happened that there was less pain with the clamp than when the pedicle had been tied and returned into the abdomen, as has been so ably advocated by Dr. Tyler Smith—clearly showing that the pain in the back, so frequently complained of by patients after ovariotomy, is not owing to traction on the pedicle by the clamp. He further maintained that the clamp is always quite safe, and is a certain security against bleeding from the pedicle, even though vomiting and straining does occur, which in some cases is not uncommon. Again, it has an advantage over ligature returned, for that may slip off and bleeding ensue. Lastly, the clamp is not so elegant as the singeing the pedicle, but possibly more safe and trustworthy. Mr. Brown did not mention whether vomiting occurred in the case he related; now, if it did not occur, he (Dr. Parson) maintained that the security of the vessels in the pedicle was not tested severely, and he feared other cases might not be so successful, for vomiting and retching after the operation might open up the large veins in the pedicle that have only been temporarily and, possibly, slenderly secured by the singeing. Should bleeding occur it would be some hours after the operation, when, in all probability, the abnormal wound would require opening up (by candle-light)—and a frightful operation it is to stop it, for he would find that there is no distinct and defined pedicle left, and, after sponging away the clots out of the abdomen, there will be an elliptical wound in the broad ligament, a comparatively flat surface, in which he would find it exceedingly difficult to secure the bleeding vessels.

The case referred to by Dr. Ritchie was that of a young lady with a very vascular and sessile cyst, operated upon by Mr.

Spencer Wells, at which he was present. There was no pedicle to tie, and nothing to be done but to put on the écraseur. She got quite well.

Dr. Parson congratulated Mr. Brown on the boldness of his treatment and the success of his case.

Mr. Brown, in reply to several speakers, said that the objection urged by Dr. Tyler Smith, of the slough being injurious to the peritoneum, had been answered by the questions put by Dr. Routh and replied to by Dr. Greenhalgh; that he (Mr. Brown) had, for four years past, repeatedly used the actual cautery in burning adhesions and arresting hæmorrhage, and in no one of the cases so treated had he had a death; and he thought that the objection ought not to deter others. He did not allude to the écraseur, because he thought there was not sufficient time in ovariotomy to use it safely, and he did not think it probable that it would ever come into use on that account. In answer to an objection that white heat might be detrimental, Mr. Brown said he did not go quite so far as to use white heat, but he stopped just short of it. To the objection of Dr. Parson, that there was fear of hæmorrhage in case of sickness after the use of the cautery, Mr. Brown replied that, whilst it was well known that many patients had died of hæmorrhage where the ligature was used, he did not think, judging from his past experience and the results of veterinary surgeons in spaying the sow, that there was any probability of hæmorrhage where the cautery was steadily and thoroughly applied.

Dr. Snow Beck read a paper on "Puerperal Fever," carefully detailing the particulars of two cases in which the uterine sinuses were shown to be pervious after death, and from which the following deductions were drawn:

1. The phenomena of puerperal fever may be produced by the introduction of poisonous fluids into the general system.

2. The uterine sinuses remaining pervious to the flow of fluids would afford a means by which the poisonous fluid or fluids would enter the system.

3. The pervious condition of the sinuses remained in consequence of the absence of that firm and persistent contraction of the uterus after childbirth which appears neces-

sary to effectually close these canals, and prevent all circulation of fluid along them.

4. The secretion from the interior of the uterus was probably sufficient, when mixed with the blood, to induce the effects observed. And it would further follow, that—

5. The various phenomena observed in puerperal fever may arise from this cause, modified infinitely by many incidental states; and the various inflammatory actions and products observed in the course of the disease would not be the essential parts of the disease, but morbid phenomena which occurred during the course of it.

6. The primary, though not the only, object in the prevention of these attacks of puerperal fever will then be to procure a firm, complete, and persistent contraction of the uterus after the birth of the child, and thus effectually to shut off all circulation within the vessels of this organ.

The author considered that the cases gave a decided negative to the opinions that puerperal fever was caused by uterine phlebitis, lymphangitis, endometritis, metritis, or any similar inflammatory condition of the uterine organs, as no product of inflammation was anywhere discovered after a careful and even microscopic examination. The results were also opposed to the opinions of Cruveilhier, who compared the internal surface of the uterus to a vast solution of continuity, and the gaping orifices of the sinuses to the open-mouthed vessels of an amputated limb. For the internal surface of the organ was everywhere covered by a soft membrane containing all the elements of the mucous membrane, and covered by a red mucous secretion; whilst the gaping sinuses could only be compared to the open-mouthed vessels of an amputated limb when the uterine sinuses were pervious and admitted fluids to circulate within them,—the point of comparison not being the open orifices, but the open canals leading from these to the veins of the general system. The comparison between puerperal fever and surgical fever was also examined and considered imperfect, inasmuch as a natural condition of the vessels of an amputated limb was compared with an unnatural state of the vessels of

the uterus, which ought not to be, and might in the majority of cases be prevented. The propositions given by Dr. R. Ferguson, in his valuable essay on puerperal fever, were examined. The author differed essentially from Dr. Ferguson on the causes of the vitiation of the blood and on the varieties of puerperal fever.

The effect of this noxious impregnation of the general system was next considered, and it was shown that the quantity modified the result in a most singular way—a small quantity being eliminated by intestinal or urinary secretion, whilst a larger dose killed. When the uterus was very lax, and admitted of a ready flow of noxious fluid through the sinuses, the woman was stricken down as if by some fell pestilence, and sank in a few hours—"where the secretions are all suspended, and the patient sinks with rapidity." Where the deleterious fluid was introduced in smaller quantity, the system, after a vain struggle with the poisonous infection, sank in a few days, the chief morbid appearance after death being extensive peritonitis of a peculiar character, copious exudation of soft friable lymph, and much serosity. To a yet smaller amount of deleterious impregnation were attributed uterine phlebitis, metro-peritonitis, distension of the lymphatics with purulent fluid; the effects being more local, and the inflammations being the consequences of the first changes induced. Whilst a still smaller amount of infection would produce low febrile conditions, extending over an indefinite period, and sometimes inducing purulent infiltration in various organs of the body. Each of these states being influenced by a variety of concomitant circumstances—as the original constitution, state of health, the character of fluids secreted, the existence of any diathetic disease, epidemic influences, &c.

On the question of contagion and the occurrence of epidemics, the author showed that the most experienced in this disease varied so much that no decided conclusion could be drawn. The prevention of the disease, it was urged, could be most effectually accomplished by procuring a complete and persistent contraction of the uterus after the com-

pletion of the labour; and that the means usually recommended were not sufficient for this object, it being generally considered sufficient to procure such an amount of contraction as to prevent any hæmorrhage, though it was necessary to go beyond this point of contraction before the safety of the woman could be secured. A nourishing and supporting diet was further necessary to remove the physical fatigue and mental anxiety of the labour, to restore the health from the waste occasioned by the previous months of pregnancy, and to enable the woman to pass through the subsequent changes which had yet to take place; much, however, depending upon the previous habits, state of health, and other incidental circumstances.

On the subject of treatment, when the disease was once developed, the principles were considered to be—(1) to prevent the further injurious impregnation of the system, either by obstructing the further flow along the uterine sinuses, or by removing the noxious fluids from the interior of the uterus; (2) by supporting the system during the struggle in which it was engaged, and by meeting any incidental complication which might present itself; and (3) perhaps a further source of treatment was now afforded, which might enable us to counteract, to some extent at least, the deleterious impregnation which had already taken place. The first would be attained by procuring, if possible, the further contraction of the uterus, or by inducing the coagulation of the blood in the uterine sinuses. But the principal curative means appeared to rest upon the removal of all noxious fluids from the interior of the uterus, by cleansing it with a tepid solution of any sulphite, or, hyposulphite of soda each day or oftener; and should any fluid gain entrance into the uterine sinuses, it would probably be more beneficial than otherwise. The means to support the system were too well known to require further notice; whilst deleterious impregnation, which had already taken place, might be met by the internal administration of sulphite of magnesia or lime, in doses of one scruple to half a drachm every two or three hours.

Dr. GRAILY HEWITT stated that, having had considerable opportunities of witnessing the disease now under discussion, he would give some of the results of his own observations, although it was impossible in a few words to include a consideration of all parts of the subject. He had long entertained the idea that a very close connection subsisted between a loose relaxed condition of the uterus after delivery and the supervention of puerperal fever. He had followed a plan of treatment based on this idea, and had frequently insisted upon it in teaching. He considered that the author of the paper had offered anatomical proof of what had been a matter of surmise among many obstetric authorities of late years—namely, that puerperal fever and allied disorders are not necessarily and inseparably connected with the existence of inflammatory changes in the tissues of the uterus and neighbouring parts. He believed, with the author, that the disease arose from the introduction of putrescent or decomposing material into the uterine sinuses, and thence into the general circulation. This was the cause in by far the majority of instances, but he believed that the poison was sometimes introduced by other channels. He could not regard puerperal fever as a disease *per se*, and he considered it would be difficult to distinguish anatomically and pathologically between ordinary puerperal fever and that condition produced by the contagion of scarlet fever or other fevers in the lying-in woman; for though the cause might be different, the effect was or might be the same. The essential part of puerperal fever is poisoning of the blood, and this may be effected in various ways. He had, as he had already stated, observed a very close connection to subsist between the relaxed uterus and puerperal fever; he had always found the uterus larger than it should be at the outset of the attack, this increase of size being accompanied with tenderness and other signs. In this respect, therefore, he quite agreed with the author of the paper. It would afford confirmation of the truth of this view of the subject to describe the treatment which he (Dr. Graily Hewitt) had for some time adopted in cases of puerperal fever and its results. Disregarding entirely and completely the old ideas as to inflammatory changes in the uterus, he was in the habit of applying the bandage very tightly over the uterus the moment the first symptoms appeared, and of administering internally a stimulant diet, including large doses of alcohol. Other remedies were used, but they were quite subordinate. Depleting and lowering medicines were wholly omitted. The quantity of alcohol given was sometimes at the rate of as much as two ounces of brandy every two hours. This treatment he had seen cut the disease short in the course of twelve hours. He had the greatest confidence in the efficacy of such treatment in bad cases of puerperal fever, having seen not a few apparently hopeless cases recover under it. In reference to the prophylaxis

of the disease, these observations were interesting. The binder served a very important purpose, and he was in the habit of paying the greatest attention to its careful application, believing that in a well-contracted uterus we have the best safeguard against puerperal fever. The facts related by the author of the paper bearing on this latter subject were very important.

The PRESIDENT said the subject was one of such paramount importance that it deserved a special discussion every year. He believed, if attention were thus continually brought to it, that much would be done in the way of preventing this the most destructive of all causes to puerperal women. It was impossible to advert now to more than one or two points. He agreed with Dr. Beck that puerperal fever was a distinct thing from typhoid or scarlatina, which often attacked puerperæ, but preserved their essential characters. On the leading idea of the paper—the necessity of contraction of the uterus as a preventive of puerperal fever—he would say, that contraction was eminently desirable to accomplish, but he had seen repeatedly puerperal fever occur in women after perfect contraction, and, on the other hand, no puerperal fever although the uterus remained relaxed. After the great discussion at the Académie de Médecine, Dr. Martineng published a memoir setting forth this view, and advocating the use of ergot and all means to ensure contraction as preservative against fever. Dr. Barnes, having under observation 2000 or more cases yearly of poor women attended by the Royal Maternity Charity, thought he was able to negative the proposition that puerperal fever was more frequent amongst the poor and badly fed. The cases in the charity were very rare. For one case amongst these women, he saw ten amongst the easier classes. As a means of preventing the loss of blood—as hæmorrhage undoubtedly predisposed to puerperal fever—he had found nothing of equal efficacy to the injection of a solution of perchloride of iron into the uterus after clearing out the cavity of placental remains and clots. He had used this plan for several years, and in a large number of cases after labour and abortion, and had always had reason to congratulate himself upon the result. The perchloride of iron had the further advantage of being antiseptic. He had certainly saved several women from death from flooding, and believed these and others had been rendered less liable to puerperal fever. In reply to a question from Dr. Timothy Pollock, the President stated that the plan he adopted was to carry in his "obstetric bag" a saturated solution of the salt. Of this solution he used one part to eight of water. But he thought that even a weaker solution was sufficient. It instantly coagulated the blood in the mouths of the uterine vessels.

Dr. SNOW BECK briefly replied, and stated that he considered puerperal fever essentially distinct and different from typhus fever,

typhoid fever, scarlet fever, or any of the acute specific diseases; each of the latter being caused by a distinct and definite poison, which might be communicated from individual to individual in the same ward; whilst the former was produced by the introduction of putrid or similar fluids into the general system through the sinuses of the uterus, when they remained pervious after a confinement, and was *not* communicated from individual to individual in the same ward. Perhaps the term "puerperal fever" was not the most appropriate, but it had been consecrated by long usage, and it was not desirable to change it without good cause. There was a great distinction between puerperal fever and febrile states occurring during the puerperal period, the former being incurable up to the present time, the latter readily admitting of cure. This distinction had been clearly drawn by Professor P. Dubois. He had used the soluble sulphites as injections for cleansing the interior of the uterus, from the opinion that they were the most effectual agents in correcting the condition of the fluids secreted. But he had no doubt other agents would be found equally and perhaps more efficacious, and amongst them possibly the preparation of iron mentioned. But if it were even admitted that this plan of treatment was advisable, and devoid of the great danger sometimes attributed to it, then an important step had been attained. He, however, would strongly urge the necessity of procuring complete and persistent contraction of the uterus, and of carrying this contraction further than was usually considered sufficient, as being one of the most effectual means of preventing this most serious disease. He thought that by separating the many diseases occurring during the puerperal period, and included under the one designation "puerperal fever," though differing essentially in their nature, course, and treatment, great good would result.

PRESIDENT'S ADDRESS.

By Robert Barnes, M.D., F.R.C.P.

Gentlemen,—My first duty and my strongest impulse on taking this chair is to endeavour to express my thanks for the honour you have conferred upon me. It is difficult, indeed impossible, to deny myself the heartfelt satisfaction of giving utterance to those feelings of personal gratitude

which rise within me when I contemplate this mark of your approbation.

But although this emotion cannot be altogether suppressed, I feel it would be inexcusable egotism on my part were I to indulge in expressions implying that your choice was in any material degree guided by personal feelings. There is only one solid claim to be called upon to take a prominent part in the administration of a working scientific body. It is evidence of having done such work in the society, or in promoting its objects elsewhere, as will furnish a guarantee of more work of the like kind in the future. It is by recognising this title as pre-eminent that our Society has flourished beyond example; that our discussions have been marked by inexhaustible fulness of matter; that they have been fertilised by that prolific spirit which springs up in and spreads from mind to mind, giving birth to new thoughts and fresh inquiries when many minds are acting upon each other in friendly emulation in pursuit of a common object. To some modest share in that work I hope I may lay claim —enough, perhaps, to raise the expectation of something better. At any rate, in accepting the office that confers honour I acknowledge a concurrent obligation.

It is by recognising this great principle of work that the Obstetrical Society of London has taken high rank and acquired just influence throughout the medical profession at home and abroad. Thus have we been enabled to link ourselves to fellow-workmen in all parts of the world, and, I trust, to challenge for English midwifery that place in the republic of medicine which it eminently deserves. English midwifery, before the foundation of our Society, was very imperfectly represented; we stand, in fact, very much alone in our method of cultivating obstetric science. The characteristic distinction of English midwifery is that it is based upon home or domiciliary practice. Our great schools in this town are not connected with lying-in hospitals. The general hospitals which form the basis of our schools have, very properly, beds appropriated to the diseases of women; and these beds, of course, receive cases of disease arising out

of labour and the puerperal state. But for the observation and conduct of labour our students are taken to the homes of the patients. Having myself lived for two years in a lying-in hospital, and attended, not without profit, I cheerfully acknowledge, the practice of the Clinique d'Accouchements at Paris, I am prepared to maintain that our English plan of teaching practical midwifery possesses advantages which are not surpassed by the hospital or Continental method. Home-midwifery gives the nicest training for the responsibilities of practice. There is a duty beyond that of simply managing a labour; it is a great and important part of our task to regulate the lying-in chamber, and to order everything that may conduce to the well-being of the lying-in woman. Seated at the bedside of the patient at her own home, the student enjoys a precious opportunity for quiet observation of the progress and mechanism of labour. Lastly, and it is the highest praise, this method of taking the student to the patient's home is the best fitted to implant in him a tender and chivalrous regard for the feelings of the woman and the duties of the mother. It is certain that society must suffer in her dearest interests where these are not respected. Great, overwhelming must be the force of those considerations which should induce us to abandon domiciliary succour to poor lying-in women, and to substitute the hospital system. The argument that I have heard the most emphatically urged in favour of hospitals is that they are necessary for the purpose of instruction. Our Continental brethren seem hardly to contemplate the possibility of acquiring obstetric knowledge in any other way. Dubois expressly defends hospitals on the ground that without them obstetric science would decay. And it would be vain to deny that much accurate knowledge has been diffused by their means, that many valuable improvements in practice have originated in them, and that a host of able practitioners have been formed in the Continental and in the Dublin hospitals. But I think we may with some confidence point to the eminent success of midwifery practice in this country—to the teaching in our schools—to our literature—and to the 'Transactions' of this

Society—to prove that obstetric science can be taught and cultivated with credit without the aid of lying-in hospitals. The forceps and the induction of labour are of English origin. Harvey, whose 'Exercitatio de Partu' would have earned for him a great reputation in our department had not the brilliancy of his other discoveries eclipsed his obstetric merit, was not indebted to hospital instruction. The same may be said of the Chamberlens, sordid men truly, but still the reputed inventors of the forceps; of Edmund Chapman, the first to teach the use of that instrument; of Sir Fielding Ould, who laid the foundation of our present accurate knowledge of the mechanism of labour; of Giffard; of Smellie; of William Hunter; of Denman, whose book will bear comparison with any printed before or after him; of Macaulay, the first to practise the artificial induction of labour; of Perfect; of the first Rigby, whose name is specially endeared to us through the memory of his son, our first President, and who, as a country practitioner, made those observations and drew those classical descriptions of uterine hæmorrhage which we still reverence for their truthfulness and sagacity.

To exalt these men, and to maintain the credit of the system which produced them, we are not driven to depreciate the opposite system cherished abroad. The bright fame of the Dublin school is intimately, but not exclusively, associated with its hospital. Illustrious teachers and practitioners have flourished, and others still flourish, on the Continent, formed in great part by hospital training; and well are these able to assert their position and extend their doctrines. They have every appliance. Their lying-in hospitals are closely connected with celebrated schools of medicine. They are mostly endowed or supported by the state. The chiefs of these hospitals are the professors of midwifery. Students from all parts of the world flock to the schools and to these hospitals, attracted by the renown of the teachers, and also by the tempting facility which the concentrated materials present in hospitals for seeing much in a short time. Then, this hospital knowledge is further diffused by

means of societies like our own. Now, I wish particularly to impress upon your attention this fact—the foreign obstetrical societies, and the other societies where obstetric science is discussed, represent hospital midwifery, that is, they draw their inspiration from and are the exponents of the hospital system. By the aid of these instruments Continental midwifery has achieved, perhaps, an undue share of authority. For want of an English society we have stood at some disadvantage. The rich fruit of the experience, of the calm and sagacious observations, of the practitioners of this metropolis, of our great towns, that rival Continental capitals in population, and of our rural districts, was but imperfectly gathered in and distributed. Now we stand upon more equal ground, ready to learn from our fellow-workmen abroad, and, at the same time, ready to give them something in exchange. In one thing which I have much at heart, I fervently trust we shall not toil without success. We shall vindicate the basis upon which English midwifery rests; we shall prove that nature may be well observed out of hospitals; we shall, by exhibiting in continual contrast the results of practice here and under the foreign lying-in-hospital system, impel physicians and statesmen abroad to re-examine that great question of the expediency of taking parturient women away from their homes. The superior safety of domiciliary practice will be made so evident to them, the frightful excess of loss of life from puerperal fever will be demonstrated to be so closely dependent upon the hospital system, that they will one day entertain a doubt whether it is right, even for the sake of instruction, to maintain lying-in hospitals at so terrible a cost.

Whilst touching upon this question of instruction I will avail myself of the opportunity to advert to the provisions in our schools for the study of the special diseases of women. Here the hospital system seems not only useful, but indispensable, and is free from all the objections applying to the herding of lying-in women together. The successful cultivation and teaching of uterine pathology and treatment are intimately dependent upon their receiving

the concentrated attention of the obstetric practitioner. This has been of late years generally admitted by the profession and by the medical corporations. Facilities have accordingly been opened by the institution of a new office in our educational hospitals, namely, that of "Obstetric Physician." But the position and duties of the new officer are hardly as yet sufficiently defined. At first he seems to have been regarded somewhat as a supernumerary; he occupied a half-recognised position on the staff; the physicians and surgeons, in admitting him to nominal rank, did not assign him any share of the hospital fees; they consulted him upon any case in the wards which presented an ovarian or uterine complication. The obstetric physician seemed a sort of hybrid animal, sprung from the impure union of the pure physician and pure surgeon. He was neither one nor the other, and there existed, and still exists, some difficulty in assigning him his proper functions, in defining his duties and privileges. Of course, this matter, like all things of a revolutionary character, could not be settled at once like a Continental constitution, but must shape itself by time and experience. But it appears to me that we are now in a position to define the scope of the service of the obstetric physician. May we not thus express it?—

The work of the obstetric physician embraces the treatment of the diseases of the female generative organs, including the disorders and lesions, general and local, which result from pregnancy and parturition.

Of course, such a definition takes something both from the physician and from the surgeon. But if we are to enjoy any distinct status at all, it must be on this condition. The chief difficulty in adjusting the relation arises from the surgical side, and I cannot help thinking it is greatly because people are arrested by the apparent anomaly of a man bearing the insignia of a physician meddling with surgery. The truth is overlooked that our surgical character is expressed in the word "obstetric." The idea of an obstetric practitioner who is not a surgeon is simply ab-

surd and impossible. Indeed, it is only recently that the taking of a medical diploma or degree has been at all common. This title has been taken in concession to public and professional opinions. But this accidental, merely nominal, circumstance has not altered, and cannot alter, the nature of our duties. We must, from the very nature of our calling, operate upon the uterus and vagina. We are compelled to explore and to detect the lesions to which these organs are liable; and it seems unreasonable that we should explore and detect them, only to call in surgeons to treat them. It is needless to point out that were this the custom we should lose a good part of our interest in the study, and that the pathology and treatment of uterine and vaginal diseases, which have been brought to their actual advanced state of perfection through that special interest, would soon fall back and be neglected. To make an office in order to promote a study heretofore neglected, and then to cut off the materials of that study, was simply inconsistent. An illustration may be useful. An ophthalmic department has been added to several hospitals. The new office has always been filled by a surgeon. But it is found impossible to restrict him to purely surgical cases. The ophthalmic surgeon takes charge of all diseases of the eye, including many which are of strictly constitutional and medical origin and nature, requiring none but the materia medica of the physician for their treatment. Let us put it in another light. If the surgeon is to say, "The obstetric practitioner must turn over to us all operations," by the same rule the physician might say, "The obstetric practitioner must turn over to us all that requires medical treatment"—for example, puerperal fever, which is not more a consequence of labour than is a slough of the vagina resulting in cicatricial atresia or vesico-vaginal fistula. Now, this mode of reasoning, strictly logical though it be, would lead to our annihilation. It is a manifest *reductio ad absurdum.*

Before concluding I have one more wish to express. It has always been the custom in learned societies to admit

new members by some formality in the presence of the assembled body. This custom serves the useful purpose of a personal introduction. Another custom requires the new member to sign his name in a book; thereby he testifies his adhesion to the rules of the society. But I see another use—we get a collection of autographs of our associates, serving as an historical record that will be consulted with interest by those who shall come after us. But we now possess another means of greatly adding to the value and interest of this historical record. At the beginning of every session we note the changes that time has made in our ranks. In all ages the man of generous mind has striven to rescue some part of himself from the scythe of the destroyer. How pleasing it would be, whilst recording the name and works and honours of a lost companion, if we knew that we had secured the likeness of the man as he acted his part amongst us! The Royal College of Physicians and the Royal Medical and Chirurgical Society have availed themselves of the photographic art to preserve the memory of their colleagues. Why should not we, a body of friends working together in pursuit of a common object, have, in like manner, our family or corporate album. Such a collection of portraits would form at once a pleasing object of reference; it would grow in importance and interest every year, and might prove a valued source of information, and a grateful retrospect to our successors. I will, therefore, beg all my fellow-members to send their photographs to the Secretary, to be collected in an album, to be preserved amongst the archives of our Society.

I would also suggest that we should make photography further subservient to our purposes by collecting and exchanging representations of objects of obstetric interest.

Gentlemen, I hope you will forgive me for the extent to which I have intruded upon you. I fear I may have other occasions to try your indulgence. But that, I know, will not be easily exhausted. I shall rely with perfect confidence on your sympathy and co-operation.

MARCH 8TH, 1865.

Dr. BARNES, President, in the Chair.

Present—31 Fellows and 6 visitors.

The following gentlemen were elected Fellows of this Society:—Dr. Carl Harrer, 16, City Road; Dr. G. F. Giles, Clifton Villa, Victoria Park Road; Dr. Fitzpatrick, 5, Clifton Gardens, Clifton Road, Maida Hill West; and Dr. Almeric Seymour, 53, Montpelier Road, Brighton.

Dr. TYLER SMITH exhibited a portion of a dermoid cyst, with teeth attached, passed per rectum from a lady who had for a year and a half previously evacuated by the same canal a quantity of hair.

ON A CASE OF RECOVERY OF A STILLBORN CHILD. UNUSUAL MARKING OF THE SKIN, SIMULATING THE EFFECTS OF INJURY.

By JOHN ROUSE, Esq., of Lyttleton, New Zealand.

(Communicated by Dr. PRIESTLEY.)

CASE.—On the morning of the 4th August I was called to attend Mrs. O—, the wife of one of the miners employed in making the tunnel under the Port Hill. Owing to the delay caused by the husband being fetched from his work

[illegible]

to come for me, I found on arrival that the child had been born nearly half an hour, but, as the female friend who was with the patient informed me, had made no attempt to cry, and was, as she believed, dead.

Upon examination I found the child (a female) and placenta both expelled, and lying clear of the mother; the funis had not been interfered with.

At first sight the infant being stillborn seemed a certainty; I could detect no action of the heart nor attempt at respiration; the surface was white and cold, and the lips livid. After a few moments, however, I detected a very slight twitching about the muscles of the chest, scarcely perceptible, but just enough to give a shadow of hope.

I lost no time in immersing the child in a warm bath, and, after more than half an hour's perseverance in the "Marshall Hall" plan, varied occasionally with inflation of the lungs by the mouth, I succeeded in establishing respiration, which at first was much impeded by spasmodic action about the glottis.

As there was a thick coating of vernix caseosa, especially about the throat and chest, I proceeded to wash it away gently with a sponge dipped in oil, while the child was still in the bath, when I was startled at seeing beneath it, upon the throat, a patch of abrasion as large as a crown-piece, just over the larynx, and presenting just such an appearance as might have been caused by forcible compression with the finger and thumb.

Had my patient been unmarried, and alone at the time of delivery, the condition of the child was such as must have given rise to grave suspicion; but her anxiety to have a living infant (having had two still-born previously), and the presence of her friend, who was living in the same house, left no room for such doubts.

The respiration improved gradually, the spasm diminishing, and in about an hour and a half from the first attempt to induce respiration the child cried, at first feebly and hoarsely.

At the end of the second day no trace of the mark upon

the throat remained, and breathing and swallowing were both perfect and easy.

P.S.—I have been quite unable to account for the appearance about the throat; the funis was not round the neck, and the intactness of the coating of vernix caseosa of unusual thickness precluded the possibility of its having been occasioned by delay, or interference after the expulsion of the head. The female present assured me that the child had not been touched.

MEMBRANE EXPELLED FROM UTERUS A FEW DAYS BEFORE DELIVERY AT FULL TERM.

By A. Harris, Esq., Camborne, Cornwall.

Mrs. M—, æt. 26, was, on September 3rd, 1864, at nearly full term with her third child. On April 3rd, 1863, she had been delivered of her second child; had suckled it until November 28th, 1863, when it died. She had had no appearance of any blood from vagina from the time of her delivery till ten weeks after the death of the child; a flow, which she called menses, and which lasted eight days, then appeared. There were several clots; she was not aware of having seen clots at any former period. She was uncertain if she were pregnant. No further appearance of blood took place, but she felt the child first on May 9th, 1864. This went on till about a week before the above-named 3rd September, when she felt a bearing down. On the 2nd of September she took a long walk, and on the 3rd felt pain and forcing in the vagina, accompanied by much hæmorrhage. Very quickly something came away, which was given to me, and which I have forwarded for the Society's

inspection. The specimen appeared quite fresh; it had the appearance of a bag, with an opening at one end. The pain and bleeding then ceased. She came dowstairs the following day, but, feeling weak, she returned to bed. I was then called in, and found the vagina dry; os uteri dilated about the size of a halfpenny-piece, margins thin; membranes tense and presenting, but nothing in any way unnatural about these organs. The fœtus was lively. Labour-pains not coming on, she went down stairs four days after, and continued about till the 12th of September, when she was delivered in a perfectly natural manner, with the exception of three or four large clots of dark fetid blood with the escape of the waters. The placenta came away without hæmorrhage; nothing unnatural was observed, and she recovered very well.

REPORT ON THE ABOVE SPECIMEN.

By Graily Hewitt, M.D., and Alfred Meadows, M.D.

The specimen consists of a structure of a bag-like shape, flocculent and shaggy on one surface, smooth and lobulated on the other. Placed in water it assumes the outline of an oval-shaped bag, open at one end, and slit up on one side, the latter being evidently artificial and not communicating with the other opening. The specimen measures about four inches in length by about two and a half in width; that which we believe to be the upper extremity is quite rounded, like a large egg. The opening at the other end is irregular in shape, and is now of sufficient size to admit of two fingers. The margins of this aperture are thin and membranous, and a ragged prolongation of it extends downwards on one side, some distance from the aperture. Elsewhere the bag is of considerable but varying thickness. The natural position of the specimen appears to us to have been this—the shaggy, flocculent surface externally; and the smooth, lobulated surface internally. A careful examination has convinced us that

it must have become inverted either during or prior to expulsion, for on placing it under water the folds and arrangement of what is now the internal surface show conclusively that this is the natural position. A diagrammatic representation of this opening, sent subsequently to us by Dr. Harris, indicates that it was probably sufficiently large to have allowed of the inversion of the bag during its escape from the generative passages.

We are of opinion that the specimen is the complete lining of a uterine cavity, and that it is the parietal decidua of a pregnancy. The microscopic examination fully bears out this view, and identifies it, both in texture and appearance, as the uterine decidua of an early pregnancy. A drawing in the possession of Dr. Graily Hewitt represents the decidua of an early pregnancy as almost identical in appearance with that of the specimen exhibited by Dr. Harris, both as regards the microscopic appearance, the texture of the sac, and the general aspect of the surfaces. Dr. Harris's specimen is, however, peculiar in one respect, viz., that the upper extremity of the bag has a rounded but slightly conical shape, unlike that of a mould of the fundus uteri, and also unlike the upper extremity of the specimen, a drawing of which is in Dr. Graily Hewitt's possession. This fact is very important in reference to the explanation which we venture to offer of the peculiar circumstances attending the expulsion of this specimen.

The phenomena observed appear to have occurred somewhat in the following order:

On the 3rd April, 1863, the woman gave birth to her second child, which she suckled until November 28th, 1863, a period of seven months, when it died. From April 3rd, 1863, to February 6th, 1864, a period of ten months, the patient had no menstrual or hæmorrhagic flow of any kind. There then occurred a sudden loss of blood, with clots and other symptoms, such as are common in cases of abortion. On May 9th, 1864, she quickened; on September 3rd the specimen now described was expelled; and on the 12th she was delivered of a fully developed healthy child. On the sup-

position, therefore, that this third child was born at full time, the woman must have become pregnant about December 7th, 1863, and it was on February 6th, 1864, that the symptoms of abortion occurred, that is to say, about two months after the commencement of this last pregnancy. These facts render it extremely probable that the specimen is the uterine decidua of a fœtus which was probably expelled in February, 1864, the date when the symptoms of abortion were observed, the decidua having been retained to within a few days of the birth of the last child.

The only possible explanation of the occurrence of this retention—an explanation which we believe to be the true one—is that the uterus in this woman is either partly or completely double; that she conceived with twins in December, 1863; that one fœtus was placed in one division of the uterus, and the other in the other; that one fœtus only reached maturity, the other perishing at two months, or earlier, while the decidua belonging to it remained closed up in its own proper division of the uterus until the time of its expulsion on September 3rd, 1864. It is stated by Dr. Harris that the specimen looked as if recently attached to the uterus, and even at the date of our report there is considerable redness and vascularity of the tissues of the specimen near what must have been its lower extremity.

The shape of the bag lends support to the view here expressed. It is conical at its upper end—such as would be expected—and there is evidently one opening in this situation corresponding to the Fallopian tube. This opening is perfectly distinct, and readily admits a rounded instrument one eighth of an inch in diameter. On the internal surface this opening is very distinct, and we believe it to be that corresponding to the Fallopian tube. At other parts of the bag there are somewhat similar openings, but they are all very small, and differ essentially in appearance from the one now described, which has a peculiar canal-like aspect.

With reference to the supposed form of the uterus in this case it may be remarked that in Kussmaul's work on 'The Abnormalities of the Uterus' will be found described and

3/4 size

W. West lith.

delineated cases of analogous kind. The uterus may be completely double, or there may be only a septum reaching nearly to the os uteri, and dividing the two sides of the uterus. In any case both uterine cavities must have become impregnated simultaneously; and though such an occurrence is not at all common, it is sufficiently so to justify reference to it in this case. Kussmaul has recorded several such; and in Vol. IV of our own 'Transactions' will be found a case, related by Mr. Grace, which very much resembles that of Dr. Harris. The uterus here was double, and gestation proceeded to about the seventh month.

All the points mentioned in this report as to the general appearance of the specimen are fairly represented in the annexed Plate I.

LABOUR IN PRIMIPAROUS WOMEN LATE IN THE REPRODUCTIVE PERIOD OF LIFE.

By George Roper, Esq., M.R.C.S.,
SURGEON TO THE ROYAL MATERNITY CHARITY.

(Communicated by Dr. Barnes.)

In common, I believe, with most obstetricians, I held the opinion that labours late in life were almost necessarily severe and difficult. The experience of several such labours, which were not only free from severity and difficulty, but which were positively easy, has led me to the conclusion that difficulty is the exception in these cases as a class. I take the age of forty-five. There is in subjects at this period of life, contrary to what is assumed, an absence of that rigidity and tenacity of structure which we meet with in those prior to the decline of the reproductive function. The soft parts about the outlet of the pelvis are thin, flabby, and elastic, from want of tone, and offer but a feeble

resistance to the passage of the child; they afford a strong contrast to the firm, plump, tonic, and unyielding tissues of middle life.

In the primipara at the age of forty-five there is generally a peculiar lean and thin, and almost wasted, condition of the soft parts which line and close the outlet of the pelvis, in consequence of which the second stage of labour is rendered easy. Assuming the cervical portion of the uterus to be healthy, the first stage of labour is also free from difficulty. It is a clinical fact observed in these cases that the uterus acts with great vigour; its powerful contraction is remarkable as compared with the uterine inertia of the multipara at this period of life; the power of the one is good and has never been used, that of the other is worn out.

On looking over Dr. Robert Lee's 'Report of Eighty Forceps Cases of Difficult Labour,' I find that 39 were primiparous cases; in 13 the age is not stated; of the 26 in which the age is recorded, 3 were in those under twenty-five years of age, and 2 over the age of forty; 21 cases occurred between the ages of twenty-five and forty. As by far the largest number of primiparous labours occur before the age of twenty-five, it is inferred from this experience that difficulties are rare under this age. Only 2 cases being recorded over forty years of age, it is concluded that difficulties at this period are not common, considerable allowance being made for the infrequency of first labours at this time of life; yet if difficulty were so essentially connected with labour at and above the age of forty-five, a larger number of cases might have been expected. As between the ages of twenty-five and forty we find 21 cases, this bears out my own experience, that cases of difficulty or severe labour in primiparous women most commonly occur at the mid period of the reproductive function, say at an age between twenty-eight and thirty-eight. The object of these remarks is not to give an authoritative opinion, nor is it desired to elaborate from statistics what might be conclusive on this point, but rather for the purpose of eliciting the opinions of the Fellows of the Society on a question in which it is felt there is some

error in regarding primiparous labours at an advanced period of life as almost necessarily difficult or severe.

The PRESIDENT observed that the paper was instructive in correcting a common belief that first labours in women at an advanced age were always severe and dangerous. He had seen many instances confirmatory of the author's proposition that these were often really easy. He had recently read a memoir by Dr. Matthews Duncan, in which it was shown that the maximum weight of the fœtus was attained by women pregnant at the age of twenty-five to twenty-nine, and that the weight afterwards fell. If this were so, we had here a circumstance that would help to explain the more easy labours of women who had passed the age of forty.

CASE OF IMPERFORATE BOWEL; OPERATION; DEATH.

By ALFRED MEADOWS, M.D.,

PHYSICIAN TO THE GENERAL LYING-IN HOSPITAL.

ON February 15th, 1865, I was requested to see the infant of Mrs. E—, born on the 4th inst., who, I was informed, had had no relief from the bowel since birth, though various purgatives had been given. I found on examination that the anus was quite perfect, but on passing a small elastic bougie into the bowel its progress was arrested at about half an inch beyond the sphincter ani. I then passed the little finger, and could easily make out that the bowel was impervious beyond that point. The intestines were already greatly distended and hard, and this was the more evident because the rest of the body was much emaciated; but the child took the breast well, and retained it.

At a consultation with an eminent surgeon it was determined to make an attempt to puncture the bowel by the anus. This was accordingly done, the knife being passed up twice for at least an inch beyond the seat of obstruction; no feculent matter, however, passed away, and the idea, therefore, that the bowel might be close by and distended, and therefore easily reached beyond the obstructed

portion, was abandoned. The question of opening the bowel in the loins or groin was considered, but it was thought unadvisable to interfere in that direction. The child was very weak and delicate-looking, and from the cuticular desquamation of the hands and feet was thought perhaps to have a syphilitic taint. Nothing, therefore, remained to be done by way of operation.

The further history of the case was simply that of increasing distension of the bowel, with obstinate vomiting, occasionally of fæcal matter; the child passed water freely, but nothing ever came by the bowel. The emaciation increased, strength failed, and death took place on the twenty-second day after birth, and nine days after the operation.

On making a *post-mortem* examination the state of matters figured in the annexed drawing was discovered. The bowel terminated blindly at about an inch and a quarter from the anal orifice, and between the two there was a round fibrous band, which was solid and quite imper-

vious, the anus itself being perfect and ending in a *cul-de-sac,* as discovered during life. Above the obstructed part the bowel was enormously distended; the whole of the colon was as large almost as in the adult, and contained a great quantity of fæcal matter. All the other viscera were healthy.

The remarkable feature in this case was the failure of the knife to penetrate the bowel, seeing how distended it was, and how apparently easy of access. Of course, had the real state of the case been accurately known—which it could not be—then, no doubt, an opening into the bowel would have been effected; but as two attempts, by some misadventure, failed to reach the bowel, the inference, of course, was that it was not near, and that therefore it was unsafe to drive the knife further with the risk of entering the peritoneal cavity. Probably had another attempt been made at a later period, when the bowel was still more distended, better success would have resulted; but, as I before said, failure at once justified the conclusion that a similar issue awaited any further attempt. I think the case is instructive in this latter aspect; it seems to show that we ought not to abandon a case of this kind, at least not early in its history. The drawing represents the bowel about half size.

The President showed a fibroid tumour which he had removed from the uterus, partly by enucleation, partly by excision. The tumour occupied the posterior wall of the uterus. The cervix was artificially expanded by incisions and mechanical dilatation. A hook having been fixed in the lower part of the tumour to draw the mass down, transverse incisions were made in the tumour by means of a staphyloraphy knife. The scissors were then used to divide the remaining attachment. There was little hæmorrhage. The patient (at St. Thomas's Hospital) was doing well.

CASE OF MONSTROSITY.

By William Gayton, Esq.

(Communicated by Dr. Bathurst Woodman.)

The fœtus was supposed to be about eight months. The mother is a pluripara. Nothing especial occurred in the gestation. The birth was fairly easy, and the fœtus breathed for a few seconds. The length of its entire body was about twenty inches. The head, and upper extremities, and thorax, were well formed, and offered no peculiarities for remark. The membranæ pupillares were absorbed. Finger- and toe-nails well formed. The lower extremities were less shapely, and were the subjects of talipes equino-varus. The anterior abdominal wall was entirely deficient from the ensiform cartilage to less than an inch above the pubes. This was due to the complete absence of the recti muscles and the common integuments. Through this space, covered only by peritoneum, the liver, stomach, spleen, and large and small intestines, were visible, and protruded considerably. The transparent omentum occupied its usual position. The funis and placenta were nearly normal, but the omphalo-mesenteric vessels were unusually distinct. On examining the back the sacrum appeared shorter than usual, and the coccyx deficient, but this was found to be caused by the last two segments of the sacrum and the coccyx being curled abruptly upwards and forwards, so as nearly to touch the pubes. No anus was found in the usual situation. The pudendum presented the following appearance, viz., there was neither penis, scrotum, nor vulva, in the usual situation; but from each inguinal fold, about an inch and a half apart, depended a penis-like body, each nearly three quarters of an inch long, about the thickness of a little finger, and quite imperforate. In the centre of a line drawn from their abdominal origin was a circular aperture, about two lines in diameter, and about half an inch in depth, which resembled an anus. This was a complete *cul-*

de-sac, and was found only to consist of introverted skin. The penis-like bodies contained only cellular tissue in their interior, and communicated with the inguinal canals. Just above the left internal abdominal ring were the left testicle, cord, and epididymis, well formed, the testicle being about the size of a horse-bean. The right testis was in its original (lumbar) situation. At least two thirds of the rectum were deficient, that viscus terminating in a fibrous cord about the promontory of the sacrum. The bladder, which was much elongated, had no other outlet, apparently, than the urachus, which was still pervious, and it appeared to communicate with the allantois. The other organs were about as usual in fœtal life. Large liver, kidneys, and supra-renal capsules, also large thymus gland; the lungs small, and very little expanded. The foramen ovale was, however, completely closed by a membranous septum. I regret that the specimen, from being accidentally allowed to float above the solution in which it was placed, became too much decomposed to allow of the further more minute examination which I intended, or to permit of its being exhibited here to-night. It was seen in its recent state by Dr. Barnes; and in the dissection I was assisted by Mr. James Adams.

ON TWO CASES OF FACE PRESENTATION IN THE MENTO-POSTERIOR POSITION, WITH REMARKS.

By J. Braxton Hicks, M.D., F.R.S., &c.,

ONE OF THE LECTURERS ON MIDWIFERY AND DISEASES OF WOMEN, AND ASSISTANT-PHYSICIAN-ACCOUCHEUR, AT GUY'S HOSPITAL; PHYSICIAN TO ROYAL MATERNITY CHARITY; EXAMINER IN MIDWIFERY AT UNIVERSITY OF LONDON, ETC.

That the continuation of face presentation with the chin pointing to the sacrum to the termination of labour is rare, whether delivery be effected by the assistance of forceps, or

by the natural efforts, is evident upon the perusal of the various works on midwifery. For while some say that they have never seen a case terminated by the uterine power alone without the assistance of art, others doubt the occurrence of such cases altogether, while some consider that these cases would have ended in the ordinary manner of face presentations, that is, by the rotation of the chin forwards beneath the symphysis pubis, had not the practitioner interfered with the course of labour, by attempts at rectification or by the use of the forceps. Indeed, one author states that delivery in the position above named is anatomically impossible.

But if we reflect on the latitude permitted to the diameters of the normal pelvis, and to the amount of variation in the size of the normal fœtal head, it seems *à priori* rash to deny the possibility of spontaneous delivery in the mento-posterior variety of face presentation, still more so to discredit the statements of those who have recited cases of delivery in this position by means of the forceps.

For, supposing that we have a normal pelvis with a capacious outlet, the antero-posterior diameter particularly ample, and the arch shallow and open, we might allow an increase in this direction of at least half an inch over the standard or mean size; and the same amount, but in diminution, might be allowed to the vertical diameter of the fœtal head, thus giving a variation of at least an inch in favour of the delivery in the position now under consideration within what may be considered the range of normal variation. This does not take into account the reduction of the vertical diameter by continued pressure against the anterior wall of the pelvis, for which we may, at a very moderate estimate, allow another half inch. And we must also recollect that this compression of the vertical diameter is not attended by much expansion of the biparietal, because the reduction is effected mostly by the slanting backwards of the bregmatic plane, thus causing the elongation of the head backwards, so that the occiput rests on the back of the neck.

If we study the diameters of the outlet of the pelvis with those of the head, it is evident that there is no reason why at times, provided the chin cannot rotate from behind forwards, the head should not be delivered in the mento-posterior position. Of course there are other elements for consideration also, but these are not insuperable, and, being reduced in some cases to a minimum, they will form little opposition to this mode of delivery. Now, Smellie, in his 'Treatise on Midwifery,' published in 1784, had described cases in which the face of the child presented to the end of labour in this position, two of which he delivered by turning at a rather earlier stage; another he rectified by the forceps into the mento-anterior position; and the fourth, the last of all his collection of cases, he delivered by the forceps in the mento-posterior position, after many attempts to alter the presentation, the forehead emerging beneath the arch of the pubis first. He gives a plate of this (pl. xxvi).

In his directions regarding the use of the forceps in face presentations he advises, in cases where the chin points backwards, before applying the forceps, to lift the head, and then, having applied the forceps, the head is to be by them rotated into the usual position. "If this cannot be done, let the operator try with the forceps to pull down the hind head below the os pubis, and at the same time with the fingers of the other hand push the face and forehead backwards and upwards into the hollow of the sacrum. For when the chin points to the back part of the pelvis the forehead is squeezed against the os pubis, while the hind head is pressed upon the back between the shoulders, so that the head cannot be delivered unless the occiput can be brought out from below the os pubis, as formerly described."

In describing his plate xxvi, showing the position of the head and the use of forceps, he says, "The head is here squeezed into a very oblong form; and though forced down so as fully to dilate the os externum, yet the vertex and occiput cannot be brought so far down as to turn out from below the pubes without tearing the perinæum and anus, as well as vagina and rectum."

In the case where he delivered by the forceps he remarks "the perinæum yielded so as to allow it to do so," but we are not informed whether it did so by rupture; judging from his former remarks, it would seem likely.

This description of the case by Smellie, it will be seen in the quotation below, was either doubted or ignored by some; while others, who did not distinctly contradict it, limited it only to those states of pelvis or fœtal head which were abnormal. Thus, Naegele, 'On the Mechanism of Labour,' in describing the mechanism of the second facial presentation, makes the following remarks:—"When, as is frequently the case, the forehead in a facial presentation is met with originally either somewhat backwards or forwards, this in no respect alters the description of the further advance of the head through the pelvis. The chin always turns itself in the course of labour forwards under the arch of the pubes, that is to say, if no faulty conditions exist, for example, in respect of room, or if no external reason to change the position of the head has led to an attempt to rectify it by converting it into a cranial one, or to have recourse to artificial delivery. In an obstetric practice of more than thirty-six years a case has never occurred to my father, if no mechanical interference became necessary, where the forehead turned forwards and the face placed itself in the usual and opposite direction at the outlet. An immature, untimely, or decomposing fœtus may readily place itself at labour in almost every imaginable position, and it is conceivable how the mechanism is in these circumstances liable to many changes, so in frequent, and by means mostly of easily understood but unusual proportions, conditional deviations from the usual progress of labour, as, for example, the expulsion of the face with the forehead directed forward, as a rule, as is stated in many of our compendia, is perfectly absurd, and depends either on their authors having seen too small a number of labours before writing them, or, among other things, such a representation owes its existence to the desire of contradiction. I frankly confess that I can give no credit to anything on the facial presentations with

the forehead directed anteriorly, adduced and detailed in these writings, and demonstrated in all their relations, and the peculiar circumstances and difficulties connected therewith (not even, indeed, by those who permit such cases to range under the rubric of 'normal labours') in as decided a tone as if they would make one believe these pieces of jugglery and rope-dancing were of daily occurrence, but to which nature never surrenders herself."

Again, *Dr. Churchill* ('Practice of Midwifery') has the following:—"The older writers describe the head as emerging from the lower outlet in face presentations, with the chin towards the perinæum; and Dr. Smellie has given a plate in illustration of this. A moment's examination will show that this is mechanically impossible; and the careful observation of Naegele and others have been unable to detect any such case."

Velpeau ('Traité des Accouchements') says it is exceedingly rare, and that for four reasons, the fourth being because it is evidently impossible for the chin, which must always appear first at the vulva, to descend in this attitude as far as the anterior edge of perinæum, unless, as Desormeaux remarks, the fœtus be an abortion, for the breast would then be entirely within the pelvis at the same time with the head, and Stein would have satisfactory reasons to maintain with the ancients that face labours cannot be abandoned altogether to nature.

Cazeau ('Traité de l'art des Accouchements,' p. 363) considers that the rotation of the chin forwards beneath the pubic arch is absolutely necessary for spontaneous termination of labour. He discusses at considerable length the mode of delivery in mento-sacral face presentations.

To say, with those to whom Naegele alludes (who are certainly not to be found this side of the Channel, witness the quotations below), that these cases were common would be very wide of the fact, yet, notwithstanding the high respect which we must give to the result of Naegele's work, I must for myself take some exception to his rigid views of the mechanism of face presentations, and, indeed, of presentations

generally. It is a fault into which he, in common with some others, has fallen, to consider the pelvis in the abstract, and to build their calculations of the possibility of delivery upon the idea of a pelvis which possesses the *average* measurements, rather than making due allowance for the variation to be found in the pelvis within the healthy standard. I will not say that this variation of the standard has been altogether lost sight of, but its want of prominence has certainly tended to cause observers to limit the possibilities of nature within their real boundaries. If, as above observed, every pelvis of the normal standard possessed the same measurements, if every diameter bore the same relation to each other, if every fœtal head possessed the same size and the same relative compressibility in all its parts, if the perinæum possessed always the same rigidity, and the expulsive forces were always the same, then doubtless, labours would be conducted always on the same plan. But as the contrary is the case, and in no two labours the same condition exists, we ought not to limit the passage of the fœtal head so strictly to this or that mode of classifying every variation as an abnormal condition.

The following quotations may suffice to show the very great difference which has existed among authors respecting this termination of face presentation:

Dr. Tyler Smith says ('Manual of Obstetrics'), "There are four presentations of the face. . . In practice it will be found that the third and fourth face presentations, or mento-posterior, are so extremely rare as to be hardly worth enumerating, and consequently our attention may be confined to the first and second only."

Dr. Ramsbotham says, "I myself never knew an instance of face presentation in which the head was expelled with the upper and back part emerging from under the pubic arch." In a foot-note he says Meigs gives an illustration, and describes a case of this kind in point.

Blundel ('Lectures on Midwifery') makes no mention of face presentation where chin is to sacrum.

Burns ('Midwifery') only remarks, "When the chin is

directed towards the sacrum, the labour is sometimes so tedious as to require the application of instruments."

Neither *Denman*, nor *Rigby* in 'Practical Medicine,' make any allusion whatever to the subject.

Dr. Murphy says, in the first edition of 'Lectures on Midwifery,' after describing the two most common forms of face presentation, "Two other varieties are described, where the ilium directed backwards towards the sacro-iliac synchondrosis; but I believe that they are very rarely, if ever, met with." But in his second edition, under "The use of Forceps in Face Presentations," he advises the operator to be careful to make out the position of the chin, so as to give it the proper rotation forwards as it descends (p. 318, op. cit.).

Dr. Hamilton only says, "When face and forehead present, the face is sometimes placed towards the pubis and sometimes towards the sacrum, though most frequently it is in the former of these situations."

Dr. von Helly, on "The Use of Forceps in Face Presentations" ('Vierteljahrschreibe,' 1859), in a paper which enters into the mechanism and treatment of these presentations, describes the rotation of the chin from transverse or diagonal forwards, which he considers to occur more commonly at the floor of the pelvis, or near the outlet. The skull entering the cavity of the pelvis, the chin glides under the symphysis pubis.

But *Professor Braun*, in a communication "On a rare Mechanism in Face Presentations" ('Monatsschrift für Geburtskunde,' 1861), describes two cases; in one of which he delivered by the forceps, the root of the nose first became visible, the chin passed over the perinæum, and then the calvareum and occiput came under the symphysis pubis in completely transposed mechanism. The child was alive. The other case was still more interesting, because the delivery of the child was effected by the natural powers, with the chin in same position as the other. Unfortunately, in this latter case the child was dead; but still, this case proves the possibility of natural delivery in these presentations,

and that there is no anatomical impossibility to the contrary.

I have in my own practice met with the two following cases, one of which resembles that of Professor Braun's first case. In the other rotation of the chin forwards took place almost at the last moment, but I have no doubt labour would have been completed spontaneously with the chin on perinæum had not the rotation taken place.

CASE 1.—*Face presentation in mento-posterior position; delivery by forceps in that position; chin appearing first; child living, and strong.*

Mrs. —, of Rotherhithe, about forty years old, has had two or three children, the last twelve years ago. Former labours easy and quick. Had been in labour when I first saw her for eighteen hours, during the last five of which she had been in continuous pain, without progress. It being a face presentation, Dr. Cregeen, under whose care she was, consulted me as to the propriety of employing artificial aid. I found the face presenting, the forehead anterior, and rather lower down than the chin, which was pointing directly to the sacrum. The presenting part was well down into the cavity of the pelvis.

As she was beginning to be exhausted I thought it would be better to give assistance. I therefore applied the forceps, and endeavoured to improve the position of the head, so as to cause the vertex to descend first; but I found this could not be accomplished, no advance was made by this mode nor by traction in other directions. The instrument frequently slipped, and was as often reapplied. The maternal soft parts were considerably swollen. I then removed the forceps, and endeavoured by my hands to alter the position of the head. I produced a slight rotation of the chin to the left side of sacrum. I then reapplied the forceps, and, finding it useless to endeavour to bring the vertex first beneath the pubic arch, as I at first attempted, I drew down the chin over the sacrum and perinæum, and, without any very great trouble, succeeded in bringing it just outside the perinæum; immediately upon this the upper part of the

head glid underneath the pubic arch, and the delivery was quickly over. The child was alive, and continued healthy the last time I heard of it. The vertex was much depressed, appearing rather as a hollow, and the head was wonderfully elongated backwards on to the neck. It exactly resembled the head of the child in Smellie's plate of this form of delivery.

The mother had an excellent recovery. Her pelvis was full-sized, but not above the normal standard; the child was rather larger than the average of males. My notes, unfortunately, do not mention the sex. The features were, of course, much distorted.

CASE 2.—*Face presentation, mento-posterior position; delivery by natural powers.*

Mrs. —, Walworth, æt. 19, primipara, rather small, delicate person. Pelvis appeared normal. She had been in regular labour nearly twenty-four hours, during which the os had dilated well and the waters had ruptured; the face had descended fully into the cavity, when the uterus had become quiescent. Mr. Charles Browne, of Camberwell, had detected the chin posteriorly, and asked my assistance. I found the chin rather towards the right side of the sacrum, the forehead forward. As the pains had gone off some time, without any other symptom to give anxiety, two doses of secale were given. The pains soon came back with plenty of power, and I then endeavoured to bring the chin anterior, by the hand. This attempt, however, was without effect; the chin continued in same position, but descending as rapidly as in the mento-anterior direction. In a short time the forehead separated the vulva, beneath the pubic arch, the face and chin gliding down easily over the sacrum and inside of perinæum, till the nose was just clearing the anterior margin; some little detention arose here, and while I was watching with interest to see how nature wouldaccomplish delivery, which appeared to require so little more effort to be effected in the original direction, the

chin rotated forwards beneath the tuberosity of the right ischium, up into the arch to the position in which it makes its exit in the more usual cases. Notwithstanding this change of position, yet, from the space there appeared to be at the outlet, and from the fact that the chin was below the coccyx and outside the plane of the tuber ischii, and from the ease with which the perinæum was being distended, I have little doubt but that the face would have escaped by natural powers into the mento-posterior position had there been more difficulty in its rotation forwards. The pelvis was about the normal size. The child quite up to the average size, and a male. It was born alive, but respiration was slow, and after remaining in that state for half an hour it died.

The remarks made by Prof. Braun upon his cases, and upon the variations of face presentation, seem the most complete of any I have met with.

From a consideration of the published cases it appears to me that our knowledge on this subject may be summed up in the following words, which include the chief opinions of Professor Braun.

That although in face presentations the form of the normal pelvis and of the fœtal head are such as, in the majority of cases, to cause the chin to rotate beneath the symphysis pubis from whatever position it originally held, yet that in some cases this rotation is deferred till the face is partly appearing externally; that in some rare cases the rotation may be incomplete, the face being delivered in the oblique mento-posterior position; that in some very rare cases, the chin unable to pass forward at all, the face is delivered by the natural efforts alone, the chin sweeping over the perinæum, while the vertex, much compressed, passes out beneath the pubic arch; but that in the greater number of these rare cases the natural powers are insufficient to expel the head, which, unable either to rotate or advance, requires artificial aid for its delivery; that in this case the face may be born either with the chin appearing first, or the forehead or vertex.

With regard to practice, a few rules seem clearly to follow from a consideration of the above.

If the chin in face presentations be posterior, and yet descends readily into the cavity of the pelvis, we might leave the case to the natural powers till it becomes arrested. It will then be best to endeavour to direct the chin forward, at first, by the hand alone.

Should no change be possible by this means, and the head be still arrested in its progress, notwithstanding good pains, then it will be desirable to employ the forceps, first of all endeavouring to rotate the chin forwards, and, failing that, to draw the head down in that manner which will be found most practicable, that is, with either the forehead and vertex first, or the chin.

It will be noticed that Smellie was mistaken that, in order to bring out the chin first, the soft parts must be lacerated; such was not the case in Braun's nor in my patient, and yet in both the child was alive, notwithstanding the pressure to which the calvareum was subjected. This is important, because it has been recommended in the earlier stages to turn, a plan which appears to me frequently to be attended with more risk to the child than is the use of the forceps.

The PRESIDENT signalised the value of this memoir as tending to fix precision to and to extend our knowledge of labour with face presentations. Certainly his own experience had taught him that these labours were not so uniformly favorable as Boer and others had found. Now and then cases occurred which called for operative aid. There were two stages at which difficulty arose:—1st. The face might be delayed at the brim. In such a case he deprecated the forceps, which could not rectify the position of the head, and would not seldom fail to extract. Even craniotomy still left the delivery of the head a difficult matter. He therefore advocated turning as the most rational course, and as giving the child the best chance, if the face could not by manipulation be converted into a cranial position. 2nd. Difficulty arose, as in the case illustrated by the author, from the head preserving in the pelvis the mento-sacral position, in which it descended. The further rotations of the head depended upon the due relations be-

tween the head of a *living child*, or of one recently dead, and the pelvis. A child long dead, which had lost all spinal resiliency, under the influence of the *vis à tergo*, was drawn downwards in a squash; it had no elasticity to enable it to rotate. This was a serious cause of difficult labour. But in Dr. Hicks' case the child was alive. It followed that the non-rotation of the chin forwards depended upon a want of relation between the head and the pelvis. In such a case, the pelvis being large in proportion, he should not despair of being able to turn, although it was better, if possible, to rectify the position of the head, or to resort to the plan of extracting the chin first, to draw this well back over the external aspect of the sacrum, so as to rest on the flexion of the head, when the occiput might be made to sweep over the symphysis pubis. Under ordinary circumstances, he believed that birth, with the chin remaining posteriorly, was nearly impossible; for as the face descended there was opposed to the pelvic brim a rapidly widening base of a wedge formed by the occiput bent strongly back upon the child's trunk between the shoulders, nearly incompressible, and too large to pass. The question of how best to treat these cases was one of vast importance, and the paper threw valuable light upon it.

Dr. William Martyn said that he had been called in a short time since to assist in the delivery of a woman who had been seven hours in hard labour without making any progress. This was her fourth confinement. Her previous labours had been very severe and difficult. One child only had been born alive—this not at the full time. In each labour the face was said to come first. On this occasion he found the face presenting, the chin towards the sacrum; the head was so fixed at the brim that he at once applied the forceps, and brought down the child very readily; it was dead, killed, he conceived, as the previous children had been, by the severity of the pressure the head had been subjected to at the brim of the pelvis. The transit of the head through the pelvis was precisely as described by the author in this form of mento-sacral facial presentations. Dr. Martyn thought that this case served to show how such presentations may or do arise; in short, that they are, or may be, natural presentations converted into facial by the form of the brim of the pelvis. On careful examination of the pelvis, both before and after the delivery, he found that the antero-posterior measurement was decidedly small, from a projection forward of the promontory of the sacrum. This projection he believed directed the head of the child, where, impelled forward upon the horizontal ramus of the pubis—presenting, as he believed it did, in the first and natural position, the occiput would not enter the brim of the pelvis—further pressure necessarily forced down the face, the occiput at the same time falling back between the shoulders of the child.

Such he believed to have been the process by which the face presented in this woman. He would venture to ask the author whether he thought this view might be correct. He (Dr. Martyn) thought that a narrow pelvic brim with a relaxed abdominal wall might also favour the mento-posterior facial presentation. The head, when born, formed an irregular cone—the upper part of the face the apex, the occiput with the neck of the child the base.

Dr. B. HICKS, in reply, reminded the Society that contraction of the conjugate diameter of brim did not form a material impediment to the passage of fœtal head in face presentation, so long as the bizygomatic diameter was less than the conjugate, because the biparietal had thereby escaped opposition to the conjugate, bringing the bizygomatic into relation with it. This was well shown in a case he had attended, where, with face presentation, there had been no very severe difficulty in drawing the head down, while craniotomy was necessary in this patient's subsequent labour with vertex presentation. Doubtless face presentation was, in some cases, the result of the opposition of the conjugate to the passage of the biparietal diameter.

April 5th, 1865.

Dr. Barnes, President, in the chair.

Present—53 Fellows and 5 visitors.

The following gentlemen were elected as Fellows of this Society:—Dr. Charles Coates, Bath; Nathaniel Heckford, Esq., London Hospital; Dr. Middleton, Brussels; Dr. E. H. Moore, Newmarket Terrace, Cambridge Heath; George Roper, Esq., 180, Shoreditch.

Dr. J. Braxton Hicks exhibited an improvement on the mode of fastening the rope in his écraseur, which will allow any length of rope to be used, thus doing away with the awkward and cumbersome addition of the endless drum of Weiss. Instead of using one hook or button on which to fasten the moving end, two hooks are now employed back to back, whereby two figure-of-eight hitches can be made, sufficient to keep the rope from slipping. Should, during an operation, the hooks come down to the end of the screw without having brought all the noose through the eye or severed the growth, the hitch can be undone, the hooks run up to the top of the screw, the ropes refastened, and brought down again as at the commencement. The hooks should be made as neatly as possible, but deep enough to hold two turns of rope.

Dr. Greenhalgh showed a new form of Uterine Tent made from the stem of the *Laminaria spiralis*; the peculiarity being that it is a hollow tube instead of the solid stick heretofore used. He also showed a new Pelvimeter, in which the index finger is made available for the purpose of measurement, the size of the pelvic brim being determined by a little contrivance fixed upon the examining hand.

The President exhibited an instrument which he had used for some time past for the purpose of dividing the cervix uteri in certain cases of dysmenorrhœa, metrorrhagia, and sterility. It resembles the scissors used for the same pnrpose by Dr. Marion Sims.

ON A NEW FORM OF CURETTE FOR THE REMOVAL OF UTERINE FUNGOID GRANULATIONS.

By J. Marion Sims, M.D.

To the inventive genius of Recamier we owe the curette for removing fungoid granulations from the cavity of the womb when they produce menorrhagia, and to his boldness we owe the efficiency of the practice which is now recognised as legitimate. The adjoining cut represents a curette that I have used for some time, and find it to answer an admirable purpose. I always precede its use by a sponge-tent. On its removal I pass the index finger into the cavity of the uterus, and by the touch determine the seat of the granulations, whether on the anterior or posterior wall of the uterine cavity, or on both.

This point settled, I place the patient on the left side, introduce my speculum, lay hold of the anterior lip of the os tincæ with a delicate tenaculum, pull it gently forwards, bend the shaft of the instrument to the required extent in the direction of the dotted line *a*, which may be at an angle of forty degrees, more or less, according to the previously

ascertained course of the uterine cavity. The uterus is still held firmly by the tenaculum, and the curette is passed thus bent into the cavity of the womb, and the anterior wall, if the seat of granulations, is gently scraped from the fundus to the os tineæ, not by lateral movements, but by drawing the instrument in straight lines from within outwards. Where the mucous membrane is not covered with granular vegetations the instrument passes unobstructed, but as soon as it comes upon these the sense of touch detects them almost as readily as it would detect denuded bone with a probe. It brings away very easily the fungoid granulations; and when we are satisfied that we have removed all on the anterior surface the shaft of the instrument is bent in the opposite direction (of the dotted line *b*) to the required extent, and the posterior surface, if the seat of granulations, is in like manner cleared of them. The operation done in this way is very satisfactory, because of its exactness. The shaft of the instrument, being movable, can be bent laterally as well as antero-posteriorly if the peculiarities of the case should require it. I do not know whether a curette of this sort has been used before. I think it better than Recamier's if used according to my plan, in the left lateral semiprone position. Perhaps it would be no better if used as Recamier's is ordinarily.

Mr. L. Mayer now makes this curette with a movable joint in the shaft, which is a great improvement.

CASE OF LACERATION OF THE INTEGUMENT OF THE FŒTUS OCCURRING DURING DELIVERY.

By R. King Peirce, M.R.C.S., &c.,
SURGEON TO THE NOTTING HILL DISPENSARY.

(Communicated by Alfred Meadows, M.D.)

Mrs. A—, æt. 29, married, and has had three healthy children born at full time, was taken in labour at 8 p.m. on March 30th; but, the pains being very sluggish, delivery was not effected till 12 at noon on April 3rd. She was under the care of Dr. Bannister, but the child was born a few minutes before his arrival. Both the nurse and the patient were so alarmed that they had not so much as seen the child, which was still under the bed-clothes; on Dr. Bannister uncovering it a feeble gasp was given and then it expired. At that time he noticed that the funis was broken off quite close to the belly of the child, and a little blood was flowing therefrom; the child was lying flat on the back, and in the position it would occupy if it had been born after a head presentation; the nurse declared that she knew nothing whatever of the condition of the cord, and had not even seen the child till that moment. On examination it was found that a laceration had taken place through all the skin and integuments, laying open the abdominal cavity from side to side, on about a level with the scrobiculus cordis, and exposing the whole upper surface of the liver. The wound had all the appearance of having been caused by some sharp instrument, but this was completely negatived by undoubted testimony. In the neck, and extending transversely, was a similar wound of the skin, exposing the deeper vessels and muscles in that situation; blood was oozing from both wounds at the time they were first seen. On examining the head it was found to be a mere membranous bag; not a vestige of bone could be felt anywhere except at the base of the skull. The lower extremities were also arrested in their development and strongly curved inwards.

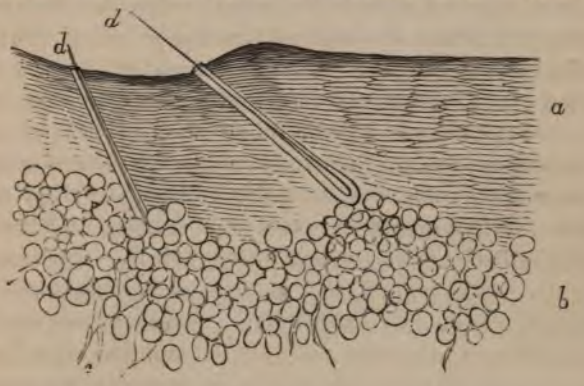
REPORT ON THE ABOVE SPECIMEN.

By Dr. George Harley and Dr. Meadows.

The specimen referred to us for examination appeared to be that of a female child which had arrived at about the seventh or eighth month of utero-gestation. Both lower extremities were club-footed; the head was soft and pulpy, and evidently contained no proper bony tissue. A large wound, four inches in length, extended across the abdomen, exposing the upper surface of the liver, and another wound, two and a quarter inches long, extended across the throat; the latter was rather more jagged than the former, which had all the appearance of having been inflicted with a cutting instrument. There was, however, no wound of any of the deeper structures, which rather militated against the idea of the wound having been done with intent. The umbilical cord had been torn off close to the body of the child. On cutting through the scalp some exceedingly minute thin scales of semi-ossified cartilaginous tissue were seen between the two layers of periosteum; there was not, however, any properly formed bony tissue. The brain appeared to be quite healthy; the lungs sank in water; the heart, stomach, spleen, and kidneys, were all healthy; the liver was healthy, but more friable than usual.

The point which especially attracted attention in the examination of this specimen was the remarkable facility with which the skin could be torn; it was, indeed, hardly possible to stretch the skin in any direction without immediately causing a laceration. We also noticed that the skin was exceedingly thin as well as brittle, and that under it there was little or no areolar or connective tissue, but only bundles of fat-vesicles heaped together. Under this adipose layer was a perfectly smooth glistening fascia, which, in the absence of any connective tissue, enabled the skin very easily to glide over its surface. When the skin was examined under the microscope hardly any yellow elastic fibrous tissue could be discovered. It was also very deficient in white or ordinary connective fibrous tissue. To the absence of these two

elements, which we regard as the result of arrested development, we ascribe the peculiar physical characters of the skin and its feeble powers of resistance. This opinion is further corroborated by the condition of the skeleton, every portion of which still remained in the cartilaginous state; here and there points of ossification were visible, but the bony spiculæ were only beginning to shoot out. Hence the



Section of Skin of Fœtus, without any subcutaneous areolar tissue to connect it with the muscles, &c.

a. Epidermic layer.
b. Thick layer of free fat-cells.
c. One or two fine filaments of white fibrous tissue. Very few to be seen; in some instances none at all.
d. Hairs. These were very numerous.

limbs could with facility be bent and twisted about, as in a fœtus whose bones have been deprived of calcareous matter.

Looking to the facility with which the skin could be torn, and to the remarkably flexible character of the entire skeleton, admitting of its being easily bent in any direction, we are of opinion that the presentation was an abdominal one, and that the laceration in the abdomen resulted from the necessary stretching of the skin in the exit of the fœtus through the vagina. We moreover believe that the wound in the neck was caused in the same way. From the result of microscopic investigation, we are further of opinion that all the peculiarities of skin and skeleton are due to a simple arrest of the ordinary process of development.

CASE OF ANENCEPHALIC FŒTUS.

By Hammett Hailey, Esq., F.L.S.

H. B—, æt. 20, healthy, in the family way for the first time, was on July 20th, 1864, seized with labour-pains, being then, according to her own calculation, about eight months advanced; pains of the usual character. On examination the membrane containing the liquor amnii protruded towards the verge of the vagina; this, on the pressure of the finger, was ruptured, and the fluid escaped in large quantities; on the escape of this fluid another membrane, equally full, presented itself, which soon evacuated its contents in a similar manner; then followed the hand of the right arm of a fœtus, the feet of which were soon reached and the child brought into the world, which presented the appearance of a healthy male child of about seven or eight months, alive, and apparently strong. (It lived for two days.) Next followed in a natural manner the fœtus represented in the annexed drawing, also with a certain amount of vitality, though not sufficient to produce, like his brother, a cry. He lived for about seven hours, or rather the heart beat for that period. There was but one placenta.

The second fœtus appeared to be quite an eight-months' child; limbs large; hands well developed,

with nails; very fat; both testicles in scrotum, the latter very large; penis as much developed as that of a child that had been born for some months. Face large, with prominent eyes; nose well developed, with large dilated nostrils; mouth unusually large. The upper portion of the cranium was quite devoid of bony covering, there being only dura mater, with the ramifications of the venous trunks; the frontal bone down to the orbits wholly absent; little or no trace of the parietal bones; the occipital could only be traced for a short distance above the protuberance for the ligamentum nuchæ. The temporal bones appeared to be perfect.

The peculiar feature in this case was the great resemblance in appearance and physical conformation which existed between this monster and the being the supposed cause of the malformation. This will be best illustrated by a reference to my Note Book:—"In the month of March, 1864, I was requested to visit a patient, a man about 21 years of age, suffering from an attack of smallpox, then in its incipient stage. I was much struck by his appearance, particularly at his head, which was very large, flat on the top, his face equally huge, with a large, flat nose and dilated nostrils, the mouth very long, with thick lips, the saliva flowing freely over them; and on examining the abdomen, I found he possessed a monstrous penis, immense testicles and scrotum in proportion, and much elephantised. He died of confluent smallpox on the seventh day."

The history the mother gave me was that he had been an idiot from birth, and was always kept locked up on account of his habit of seizing any female who came in his way, taking improper liberties and exposing his person; he had only a few days before insulted a young woman in the manner described.

When this child was born, although deficient of the upper portion of the cranium, the resemblance to the idiot I have just described was so perfect, not only in features, but in the development of penis and scrotum, that I soon questioned the mother on the subject, and found that she was the young woman who had been frightened by this idiotic monster at the early period of pregnancy.

A CASE OF ŒDEMA OF THE LOWER HALF OF THE BODY, AFTER A FALL IN THE SEVENTH MONTH OF PREGNANCY.—PREMATURE LABOUR.—RECOVERY.

By Adolph Rasch, M.D., M.R.C.P.,
PHYSICIAN TO THE GERMAN HOSPITAL (EASTERN DISPENSARY).

W. G—, æt. 24, always enjoyed good health; never had the slightest œdema. On September 3rd, 1864, being then at the end of the seventh month of her second pregnancy, she slipped while carrying her child (sixteen months old) up a flight of incredibly steep and narrow worn-out stairs, and went down on her right breast and belly about a dozen of stairs. She felt great pain, and found herself the following day swollen all over her belly and legs. A general practitioner attended her for a week, and, declaring her hopeless, the case was transferred to me. When I first saw her, on September 12th, I found the expression of countenance healthy, lips of a beautiful purple, tongue clean, her intellect undisturbed. No œdema of face or any part of the upper half of the body. Right mamma tender from a bruise. Enormous anasarca of the abdomen, disappearing above the navel; the cicatrices of the last pregnancy resisting the infiltration by serum, the skin was raised into large blisters, each corresponding to the area between two cicatrices. Right hypogastric region more swollen and resistent, and more painful than the left. Strong movements of the fœtus. The whole of both legs and feet œdematous, the right a little more so. No pain in them. The labia distended into huge water-bladders of the equal size of a very large fist. Pain distressing. The vaginal examination, which had to be done very carefully not to cause too much pain, showed the anterior lip œdematous, the head presenting. Urine, which was passed freely, quite clear, of the usual colour; on boiling showed much albumen, quite a third part of the volume. *No casts* were found. Pulse natural.

I gave some diluted nitric acid, and proposed premature labour if she should not soon get better. To relieve the very painful pressure in the labia I punctured with a pin, causing thereby some temporary relief.

On the following day I found her in the same state. But for her helplessness and pain from the œdema, she seemed well, and to some extent enjoyed her food. Albumen in the same quantity, urine of natural colour. Œdema increased, but not extending higher upwards. This having been going on now for ten days, and the fœtus being living and viable if born, I thought it right to induce premature labour, as by emptying the uterus I expected to take away the cause of the œdema and prevent gangrene. With great difficulty the patient was made to take four scruple doses of secale on the 14th of September. Pains continued all night, and stopped at seven in the morning. Not wishing to have any pain, she discontinued the powders. In the afternoon I found her without pains, the os dilated to about the size of a shilling. Expressing herself a little better and unwilling to take anything, I consented to give her another day or two's chance, but the œdema and uneasiness again increasing I introduced (September 16th, 9 p.m.) a No. 12 elastic male catheter into the uterus, gently passing it up behind the fœtal head. The membranes were not hurt, and the catheter kept in, the injunction to the midwife being not to remove it until the labour was fully established. The following morning she took half an ounce of liquor secal., which I had ordered to be in the house in case it should be wanted for a post-partum hæmorrhage. Pains set in in the evening, and I found the catheter still *in situ* on September 18th, when the os was nearly dilated and the pains good. I left the case to the midwife, and the child was born alive at 8 p.m., but died after half an hour, certainly without any efforts of the midwife to keep it alive. When I visited in the morning, the patient felt comfortable, the œdema being much less. On the fifth day all œdema and the albumen in the urine had perfectly disappeared, and the patient was with great difficulty kept in bed the usual time. She was

always well afterwards, as I had an opportunity of learning from herself some weeks ago.

The placenta had unfortunately been thrown away before I called. The child had nothing to attract notice except its soon getting blue after death. It was already dressed for interment, and the dark room besides prevented an accurate examination.

The first point of interest in this case is the diagnosis of the cause of the œdema. That the latter, in the first instance, was caused by the fall on the gravid uterus seems to admit of no doubt, since the woman was perfectly well up to the time of the accident, and never had any œdema before, not even in her previous pregnancy. The great quantity of albumen in the urine might have suggested Bright's disease; but the urine being quite clear and of the natural colour, containing no casts, and its secretion not diminished, I dismissed this thought, the more readily as there were no general symptoms to justify it. Phlegmasia alba, for obvious reasons, it could not be; I could, therefore, not otherwise satisfactorily account for the symptoms but by some pressure on the lower part of the vena cava inferior, which impeded the reflux of the venous blood from the lower half of the body. The gravid uterus, which, by the peculiar fall, must have been pushed upwards and backwards, especially on the right side (as the bruise of the right mamma and the pain in the right hypogastric region clearly showed), could easily produce such pressure on the vena cava inferior, which is very favorably situated for it, especially where it passes over the right side of the promontory. Thus, œdema of all parts supplying the vena cava inferior below the point of compression must be caused, including, of course, the lower part of the uterus. The cause of the albuminuria and the want of other symptoms are explained by the same pressure, especially the total absence of any œdema in the upper half of the body, the normal pulse, good appetite. The speedy disappearance of all symptoms after emptying the womb seems a final proof of the correctness of the diagnosis. The only point which remains to explain is why the uterus con-

tinued the compression of the vessel so long after the fall. Whether intestines kept it back, or whether the increase of the uterus by the œdema was the cause, must remain matter of speculation, as the state of the woman did not permit of observing facts to elucidate that point.

To remove the dangerous œdema, I had to remove the impediment to the circulation. Change of posture had been unwittingly tried by the restless patient without any effect. Admitting the correctness of my diagnosis, medicines could not be of any use. By premature labour, therefore, I hoped to terminate the case favorably both for mother and child. The ergot of rye I gave with great reluctance, as in several other cases I found in the introduction into the uterus of an elastic catheter a means of exciting contractions free from the alleged deleterious influence of ergot on the fœtus. At last I persuaded the patient to allow the application of the catheter; but, feeling uncomfortable, she swallowed the liq. secal. without my knowledge, with the hope of preventing labour-pains! How far the subsequent death of the fœtus is to be attributed to the large doses of secale is a matter of conjecture, especially as the great negligence of the attending midwife may have helped to produce the unfavorable result as regards the child.

No other medicine was given.

I should like to take this opportunity to call the attention of the Society to the above-mentioned mode of inducing premature labour, suggested and first practised by Professor Krause, of Dorpat, as it does not appear to have been tried in England. After making warm injections into the vagina for some days (the douche* exhibited to the Society in October, 1864, will be found a very handy instrument for throwing up unlimited quantities without any exertion), a thick elastic catheter or bougie is introduced into the womb, passing it gently up, behind the head if presenting, on the posterior wall of the cavity, and tying it outside to some bandage to prevent its slipping out. Having an instrument sufficiently stout (I used a No. 12 male catheter,

* 'Obst. Trans.,' Vol. VI, p. 224.

without director) and pliable, it can be easily introduced without rupturing the membranes, which, of course, is of great importance to the child. The pains soon begin, and the labour goes on under very favorable conditions. I first did this some five years ago, and have since done it several times, once in a case which our learned President was good enough to see with me. All the children were born alive.

Professor Valenta, of Laisbach in Austria, has lately published eighteen cases of premature labour induced in this way ('Wien. Med. Halle,' 1864). The warm injections were not used by Professor Valenta, but still his results are highly satisfactory. Dr. Barnes mentions this method in the 'Transactions' of the Society, vol. III, p. 111.

Dr. Tyler Smith remarked that this operation was much practised by Professor Simpson in Edinburgh.

In reply to Dr. Graily Hewitt, Dr. Rasch remarked that a distended bladder could not have been the cause of the œdema, as there were no symptoms of retention. He also differed from Dr. Hewitt as to the possibility of coagula in the vena cava having caused the œdema, as they could not have disappeared so rapidly without symptoms of embolism. He (Dr. Rasch) could not explain the case otherwise than by pressure of the uterus on the vena cava, which was very favorably situated for that condition where it passes over the right side of the sacral promontory.

CASE OF MONSTROSITY, WITH REMARKS ON THE INFLUENCE OF MATERNAL IMPRESSIONS ON THE FŒTUS IN UTERO.

By Alfred Meadows, M.D., M.R.C.P.,

PHYSICIAN TO THE GENERAL LYING-IN HOSPITAL.

On the 22nd February, 1865, I was requested to attend Mrs. S—, æt. 22, who was in labour with her second child at the full period of gestation. It was exceedingly difficult at

Dr Westmacott del.

1/8 size.

W West lith.

that time to make out the nature of the presentation; the child was high up, the pains not very frequent or severe, and the os but little dilated. At 5 a.m. on the 23rd, labour had so far advanced that the os was dilated to the size of a small orange; the membranes were still entire, and through them the head, hand, and foot, could be plainly traced. The latter, however, was so low down, pushing before it the membrane, that it seemed undesirable to attempt to return it; the hand was easily replaced, but in doing so the membranes ruptured, a little water flowed, and the right leg descended. In a few more pains this leg was born, then the left leg came, and then the abdomen, the whole child being expelled quickly after, when the remarkable appearance pictured in the accompanying drawing presented itself (Pl. II). As may readily be supposed, the first glance of such a monster as it emerged from the vagina occasioned no little astonishment; it was difficult indeed to say what was coming, the whole thing came out *en masse*. The uterus contracted firmly, and no more blood was lost than in ordinary cases. One thing was noticeable, namely, a remarkably scanty secretion of liquor amnii; the reason of this is now obvious. The child can hardly be said to have been alive, and yet it was not quite dead at the time of birth; the movements had, however, been plainly felt a short time before, and its death was probably the result of pressure upon the abdominal organs and circulation during the passage. We can hardly be surprised, I think, at such a result; and had it been otherwise there would be little cause for congratulation; indeed, in such a case we probably show the most mercy and the purest sympathy, and thereby perform our highest duty by allowing death to hold its prize. It is curious to speculate as to the possibility of life in such a case. The fact that the child had lived out its term of intra-uterine life, with all its abdominal viscera thus exposed not only to contact with the liquor amnii but to the constant rubs it would receive from the movements of its own limbs, all this suggests the possibility of life being compatible with such a state, at least for a time. Strange, indeed, would it have been to witness

development and growth under such circumstances; curious the revelations which might have resulted from observing the daily changes which these organs are called upon to perform. This, however, was not to be, and instead thereof we gain the less interesting but still remarkable account afforded by a post-mortem examination, which reveals, as we shall see, other difficulties to the maintenance of life than those at first apparent.

The accompanying drawings, Pls. II and III, exhibit at a glance most of the remarkable features in the case; still it may be well here to enumerate them. It will be observed, first of all, that the entire front of the abdominal wall is wanting, so that the stomach and intestines, the liver, the spleen, the pancreas, the kidneys and their capsules, the ureters, and their several peritoneal coverings, are all exposed, and, as it were, placed external to the abdominal cavity. All these viscera were intact, with the following exceptions—the large intestine ended at the left iliac fossa in a blind pouch filled with meconium; the ureters ended in a small tubercle, probably a rudimentary bladder, about the size of a pea; it was solid, and contained no cavity whatever. The ureters were pervious, but in no way distended; indeed, they were quite empty, so that it is clear that, though the kidneys were quite perfect in structure, but small in size, no urine whatever was secreted; and it seems to me doubtful whether urine ever is secreted during intra-uterine life. I have now seen several cases in which the kidneys were entirely absent, the children being born alive, though they lived but a very short time; their deaths, however, were apparently in no way attributable to this defect. It would be interesting to inquire whether this is the rule or not; and, if it be, then how is the elimination of urea effected; or, is such elimination required; and if not, why not?

On further examining the child I found that there were no sexual organs, neither internal nor external, nor was there any anal orifice, nor any external urinary passage.

All above the diaphragm was quite normal; the thorax, arms, and head, were fully developed. Below the

Dr Westmacott del.

trunk the lower limbs were of normal size; but the right thigh was a good deal bruised, and the limb was set on to the pelvis reversed, that is, with the knee and toes directed backwards.

In the place of the umbilical cord a broad ligamentous band connected the placenta to the child; it was about two or three inches long between the child and placenta, and so broad that it extended round at least two thirds of the circumference of the abdominal opening; in it, at its upper part, were collected all the large placental or umbilical vessels. This membranous connection could very well be made to cover over the whole of the abdomen, and there seemed little doubt that it was indeed an expansion of the proper abdominal covering. The placenta was rather smaller than usual, but was otherwise healthy.

On examining the bony structures I found that in front the pubic bones were entirely wanting, the front wall of the pelvis being formed by soft parts. The pelvis itself was also exceedingly shallow, for the sacrum and coccyx curved round so sharply as speedily to fill it in from below. At the back, a double spina bifida existed, extending from the last lumbar vertebra down to the coccygeal bones, the whole of the posterior arch of the sacrum being deficient. Above this point the spinal column was rather sharply turned laterally and to the left. With these exceptions, and the consequent distortion of the thoracic walls, all the rest of the skeleton was quite normal.

Now, the first question which occurs for consideration in such a case as this is, How could this state of things have been brought about? I do not think I am far wrong in attributing it to some morbid action, probably inflammatory, of a portion of the visceral surface of the placenta, occurring early in fœtal life, perhaps at about the third month. If we suppose, for instance, that about this time the secretion of liquor amnii was scanty, and that thus the abdominal surface of the fœtus was brought into prolonged contact with the visceral surface of the placenta or membranes, the subsequent steps are easily understood. Such is the opinion

suggested by Dr. Simpson in similar cases, and it appears to me quite consistent with all that is known of the pathology of fœtal life.

But now comes this further consideration, which is suggested by the explanation the patient herself volunteered as to the cause of the deformity. She stated that during the earlier weeks of her pregnancy she was greatly horrified by being shown some of Aristotle's plates, in which were exhibited some deformities resembling this, and specimens of other monstrosities.

I know it is the fashion rather to ridicule the idea that the mind of the mother can any way influence the fœtus as regards its formative development, and I do not anticipate that any remarks of mine will settle this much vexed question; but, if I am not mistaken, much good may result from a formal declaration of the opinion of this Society. I do not hesitate to avow my conviction, formed after no little thought upon the matter, that the mind of the mother can and does sometimes so interfere with the ordinary processes of nutrition and growth in the fœtus, as variously to check or modify its development in whole or in part, and thus to produce deformities or monstrosities. At the same time I would have it understood that, while accepting the general principle, I by no means pledge myself to identify all the stories which are given by mothers with the effects which are said to have resulted therefrom. But it does appear to me that there are facts and statements recorded by competent witnesses which it is idle to laugh at as old women's fables, and which are really more scientifically explained by accepting, than by rejecting, the theory in question.

If I am asked, as doubtless I shall be, how to account for such phenomena, how to explain the connection between the supposed cause and the effect, I think I am fairly entitled to turn the tables on the objector, and ask him how he would explain any of the known effects of mind upon matter. No one, I suppose, doubts that mental impressions, as they are called, do exert some influence over physiological processes,

and there is no essential difference between these and pathological processes; therefore, until my objector can explain what he himself admits, I do not feel that my argument loses more than his by the want of an explanation.

So far as I know, the great, perhaps with many the only, objection to the doctrine here contended for is, the absence of any proof of nervous connection, anatomically, between the mother and fœtus; it being held that without this connection there can be no transmission of mental impressions, and therefore no tangible results from them. But surely this is a very materialistic view of the question, and, if accepted, would compel us to believe that mind is limited in its operations to the exact boundaries of the nervous system; in other words, that it has a material form corresponding to, and confined by, the nervous centres and their multiform ramifications. Such a belief is utterly incompatible with what is known of the relations of mind to matter, and of the power of mind over the body. These force upon us the conviction that mind does in some mysterious way operate across matter, something in the same way as the electric fluid will pass across a certain space between two conductors.

Animal electricity, we all know, exercises a most potent influence over the nutritive function; primarily, no doubt, this electricity acts through nerves: but, just as ordinary electricity will pass across space, the extent of the latter being determined by the tension, as it is called, of the former, so animal electricity will equally traverse the space between its proper nervous conductors, and so act upon the intervening tissue and modify its nutritive processes. It is only in this way that we can explain the known influence of mental impressions on tissues which are known to be destitute, or nearly so, of nerves. And as it is known that mind acts principally by a sort of electrical excitation, we can readily understand somewhat, at least, of the nature of the process by which mind acts upon matter; we seem, too, to get a glimpse of the way by which, as I humbly suggest, strong mental impressions may produce equally

strong electrical changes, and so perhaps lead to great and abnormal results in the nutritive processes. No doubt also the fact before alluded to, viz. that strong currents will pass through space from one conductor to another, helps to explain how, in the absence of any direct nervous connection between one tissue and another, strong mental impressions may thus act upon them. The applicability of such reasoning to the case of the mother and the fœtus in utero is apparent, and I venture to think that if the mind of the mother can exercise any influence on the fœtus in utero in the direction here pointed out, it must be in some such way as this; the only requirement which seems really essential is, that there should be some kind of material along which the mental, nervous, or electrical influence may be carried; and if the latter be, as is probable, the correlative, as it were, of the mental force, it does not, I think, require much argument to prove that, in cases such as that we are now considering, this force may easily reach its destination and the scene of its future working, either along the umbilical cord, or even across from the inner surface of the womb at any point to the nearest surface of the child. Indeed, I hold that the spiritual part of individuals, so far as it can be said to have shape at all, is only bounded by their external physical lineaments, and certainly includes all and every part within those boundaries, as well the gravid as the virgin uterus.

If, then, it be conceded that some sort of influence may be exerted through the mind of the mother on the fœtus in utero, the next point of inquiry is as to how particular impressions present to her mind are worked out, as it were, in bodily form. I freely allow the extreme difficulty of answering this satisfactorily; but I would remark that it is surely *à priori* more likely that the effect produced should at least bear some resemblance to the dominant idea than that there should be no similarity at all. I may also, I think, appeal to the common experience of every one for evidence of the marvellous power which the mind exhibits of moulding, as it were, the bodily form to its spiritual likeness. What is

that which we call "character," and which we diagnose by sight in man's outward expression, but the corporeal effects of spiritual agency? Every lineament of the face, its curves and angles, are wrought by an invisible agent, whose marks become indelibly fixed by its unceasing action, so that the accurate observer may read it off, just as the pathologist sums up abnormal features in monstrous growths. Thus spirit moulds the ductile matter of the body, and masters the forces to which it is otherwise obedient, till it involuntarily reveals its truest likeness.

If this be the course of ordinary circumstances, it is, I believe, in some such way that the extraordinary effects which follow extraordinary states of mind in pregnant women are to be explained. To call these "freaks of nature" is to try to clothe our ignorance with that pretence of knowledge which a high-flown phrase enables us to assume. I doubt, indeed, if there be such a thing as "a freak of nature," in the sense in which it is ordinarily meant, viz., some course of action which is independent of nature's ordinary workings. I believe, on the contrary, that there is as much "law" and "order" in monstrous growths as in the development of the most perfect beauty. Nor is it any more satisfactory to ascribe these defects, as some have done, to faults in "the primary impulse of development;" for, to say nothing of such a theory being utterly incapable of proof, it only shifts the difficulty to other ground, and leaves us still in the dark as to the cause of this error in the "primary impulse." Moreover, it is impossible to believe that it can have had any real effect in many of the cases recorded, for this "primary impulse" must originate in one or other parent, and when the monster bears, as it does sometimes, a far greater resemblance to one of the lower animals than to man, we cannot believe that such a result was due to any dynamical condition of human germs.

Further, it has been objected to the view here taken that if the assumed cause, maternal imagination, were really the efficient agent, the resemblance between the idea and the fact ought to be greater than it often is. I do not think the

objection a valid one, because the amount of deformity only shows the degree to which force has, as it were, conquered matter, and how far it has failed of its object; it proves nothing more.

Great stress has also been laid on the fact that during the earlier weeks of fœtal life the relation between the fœtus and the parent is one of simple contact; hence it is argued that no mental impression could reach it to produce the effects described, and yet many of these deformities must have commenced at about this period. I think I have already answered part of this objection; and as to the latter, of course it is not pretended that mental impressions are the only, but that they are an occasional, cause of bodily deformity.

Again, it is urged that the fact that monstrosities occur among the lower animals is proof against this theory, because it would be ridiculous to suppose them to be the sport of mental emotions. I can only say, in reply, that I have no more doubt of the existence of mental emotions in the lower animals than I have in the case of man; and I think any one who has studied the lives of domesticated animals, and has watched them during the period of pregnancy, must have seen how very emotional they are, and what solicitude and care they often exhibit at such times.

Until, therefore, some other explanation is offered of the many cases of monstrosity which crowd obstetric literature than that they are mere freaks of nature, I for one am prepared to accept the doctrine that among the many causes of bodily deformity the influence of the mind of the mother deserves a by no means unimportant place.

Dr. William Martyn said he had heard from his friend Dr. Ballard, but yesterday, of a case he would relate in connection with this subject. A woman, far advanced in pregnancy, had a daughter, five or six years of age, suffering from diphtheria; in this case the soft palate sloughed away, and the child died from the disease. The mother frequently looked into her child's throat; she was much affected at its condition and death. Soon after—a

month or two, he believed—she gave birth to a child, perfect in all respects except that its soft palate was defective, was, in fact, cleft and scanty. The mother had a strong conviction that her infant was affected in its throat by the emotions she suffered from the state of her daughter when in diphtheria. Now, this case raises the question (supposing offspring may be affected in their development by certain conditions of the mother during gestation), as to how late a period such conditions of cause and effect are possible. Dr. Martyn is aware that it is generally held that defects in the development of a child in utero can only take place by impressions at a very early period. Yet he conceives that the case he has detailed has as much probability of cause and effect in support of it as most of those recorded. Another case occurred to him, in his own practice, which he will briefly mention. A woman in the early months of her first pregnancy was called upon to open her street door, when a monkey, taken about for show, sprang upon her. She was so much distressed by this that she was said to have fainted at the time, and throughout her pregnancy she often referred to the circumstance with horror, and expressed her belief that the child she carried would resemble a monkey. In due time the child was born—it was frightful to see—the face was much distorted, the mouth and upper lip were cleft in the nasal fossa; two or more of the limbs, and some of the fingers, were nearly severed by circular indentations, &c. One can scarcely reject the possibility of the shock of the mother affecting the form of her child in this case, and Dr. Martyn believes that the author has offered the best suggestions that have been published as to how the effects may be brought about.

Dr. Rasch said he had listened with great pleasure to Dr. Meadows's paper, which boldly took up what was generally left to women, but which certainly deserved scientific investigation. The belief in the influence of mental emotion on the formation of the fœtus was as old as it was general amongst women. The great difficulty was to establish facts, as the mothers always recollected something from their pregnancy *after* they had found something abnormal in their children. Dr. Rasch had seen two cases which had somewhat struck him, and of which he had taken notes. Two boys from different parts of Germany were brought to him with scarcely any foreskin, looking exactly like circumcised little Jews, but without any cicatrices. Both women narrated, with great emotion, how they had seen during their pregnancies little Jews so cruelly treated that they could not forget it! They both had been present at the well-known Jewish rite. He ought, however, to mention that he had observed the same state in other little boys where no such story was volunteered, and where the mothers *did not know that this state was abnormal.* He considered this influence on the fœtus an open question, which

he had made up his mind to help in solving whenever there was an opportunity of doing so,

Dr. TYLER SMITH said that he agreed with very much that the author had urged so forcibly in his paper, and especially as to the general question of the influence of the mind of the mother in producing deformities of the fœtus. With reference also to the case of the lower animals, he might refer to the remarkable and well-attested case which he had recorded in his 'Manual of Obstetrics.' A gentleman had a valuable thorough-bred retriever bitch, which, while on the heat, showed great anxiety to be covered by a common cur, and was very unhappy when the latter was driven away, so much so that, though she was afterwards lined by a dog of similar breed to herself, she still appeared distressed for her former love. In due course she had her litter of pups, when, strange to say, they exhibited little or no evidence of being the offspring of either father or mother, but showed a strong resemblance to the cur for whom the mother had pined. This case, he thought, bore out the remarks of the author as to the existence of mental motion in the lower animals.

The PRESIDENT observed that the instances most strongly bearing upon the question were those in which pregnant women stated explicitly the emotions supposed to influence the form of the fœtus in utero which they had undergone. One such case had been placed in his hands by Dr. Hassall, of Richmond. Certainly the facts of this case were very remarkable, inasmuch as the event singularly confirmed the statement of the woman made before her child was born. Dr. Barnes remarked that malformations were common amongst birds as well as quadrupeds; and that in birds it must be concluded that any mental impression must be imparted in the earliest stage of development, *i. e.* before the ovum was invested with the shell. He cited an anecdote from Captain Speke, which showed that in some tribes in Africa the belief prevailed that emotion in the *father* might produce monstrous births. The traveller had ordered his native huntsman to expose the embryo in a pregnant doe. He shrank from the task, fearing lest the kid striking his mind should metamorphose his wife's future progeny to the likeness of a fawn.

MAY 3RD, 1865.

Dr. BARNES, President, in the chair.

Present—46 Fellows and 12 visitors.

The following gentlemen were elected Fellows of the Society:—Dr. H. R. Hayes, Basingstoke, Hants; George Moseley, Esq., 51, Priory Road, Kilburn; T. S. Hutchinson, Esq., Sutton, Surrey; I. Baker Brown, Esq., jun., 17, Connaught Square.

ON A RARE FORM OF EXTRA-UTERINE FŒTATION.

By J. BRAXTON HICKS, M.D., F.R.S.,

ONE OF THE LECTURERS ON MIDWIFERY AND DISEASES OF WOMEN, AND ASSISTANT-PHYSICIAN-ACCOUCHEUR, AT GUY'S HOSPITAL; PHYSICIAN TO ROYAL MATERNITY CHARITY; EXAMINER IN MIDWIFERY AT UNIVERSITY OF LONDON, ETC.

MRS. B—, æt. about 35; three children; healthy woman; admitted into Guy's Hospital under me, May, 1865. About ten days before admission she applied to me as out-patient for metrorrhagia. Its character led to the supposition that it might be produced by an irregular condition of conception. I found the uterus larger than usual, and behind it a tumour. While examining the nature of it I felt a decisive movement in it, which was instantly recognised as that of a fœtus. A still more careful inspection showed that a living fœtus was situated between vagina and rectum, in the recto-vaginal pouch of peritoneum. The walls of the cyst seemed to be so thin as to add nothing to that of the vagina; there was also a flaccidity of it, so that the parts of the fœtus within reach could be fairly made out,

namely, the pelvic extremity. Its size was about that of a three and a half months' fœtus of normal pregnancy, which corresponded to the date of the conception, as nearly as could be reckoned from other circumstances.

It was as low down in the pouch as it could possibly be, and its upper part could be felt just above brim on right side. As she had a very severe attack of collapse and sharp pain in the lower abdomen for a short period a few days before, she was taken in under me into Guy's Hospital, in order to be kept at rest, and to consider the best mode of treatment.

I found, on full and cautious examination, that the upper part of the fœtus became indistinctly blended with a swelling behind the uterus, so that it was not possible to recognise its parts higher than the lumbar region. The fœtal movements, it may be mentioned, were always well marked, the leg being first touched. From the position in which the ovum was placed, and from the small apparent chance of doing anything to advantage surgically after its full growth, coupled with the probability of great risk throughout, I was very anxious to arrest its growth as soon as possible, without causing any displacement. To effect this, about ten days after admission, I employed a strong galvanic current, one pole being placed externally on the tumour above brim, the other on the lower part of tumour in the vagina. As this produced no effect, after another ten days I employed it again, derived from four cells of Smee's battery strongly charged, assisted by a good induction coil. This, again, was without the effect intended. These applications were under chloroform. I may here mention the fœtal movements wholly ceased during its administration.

After this I also endeavoured at various times to find the funis, in order to press upon it, but at no time was able to reach it, at least not to detect its pulsations.

After she had been in the hospital five weeks I adopted the expedient of puncturing the fœtus, and selected the vagina as the channel. Having placed the patient again under chloroform, I passed two [illegible] within the vagina

on to the fœtus about two inches upwards, and along them introduced a small trocar through the vaginal wall into the fœtus. The slight resistance the instrument met with at first was easily overcome, after which it seemed to enter some very soft parts. Having gently swayed this about, without any general motion of the fœtus, I withdrew the trocar; no bleeding followed.

Chloroform produced very severe vomiting, which lasted for three days without cessation, accompanied by great distress and straining.

A good deal of tenderness in left inguinal region ensued after the operation, with a fulness which had not been present before. There was no general tenderness of abdomen, but a furred tongue and pulse at 100. These symptoms continued without much variation, though rather for the better till the fifth day after the puncture, when sudden collapse came on, with anæmic appearance. Small, thready pulse, which clearly indicated internal hæmorrhage. This lasted about twelve hours, when she died.

Post-mortem examination showed about two pints of fluid blood in the peritoneum. The uterus reached about one inch and a half above pubis. The omentum adherent to the fundus, and the mass connected with the uterus. The uterus with the masses adherent were carefully removed; and on examination the uterus was found to be enlarged about three times its natural size. A cyst was adherent on its left side, and nearly whole of its back to the fundus. This cyst was about four inches in diameter when distended with the fluid it contained, which was like purulent serum.

The cavity was lined with flaky lymph. At its most depending portion, which reached about the level of the os uteri, was a circular opening about one inch in diameter. When the fluid was removed, the membranes of the ovum were seen slightly bulging into it, containing clear liquor amnii. The membranes prevented the escape of the purulent fluid into the recto-vaginal pouch of peritoneum, the whole of which space was occupied by the fœtus. Upon opening this pouch from below, the ovular mem-

branes were found to be closely attached to the peritoneum; within was the clear liquor amnii and the breech of the fœtus, which was then drawn down. The funis ran up to the upper part of the pouch to the situation of the placenta, which was at the upper part of the ovum, and adherent to the posterior surface of uterus and right side, as much as was not occupied by the cyst. From what could be discerned, the ovum, which was springing up out of the pouch, was wholly independent of any covering, being where it came in contact with the peritoneum of that pouch.

Dr. ROUTH thought that Dr. Hicks' case called for remark in reference to treatment. The plan adopted had killed the fœtus, but had not saved the woman. She had died of internal hæmorrhage, and this mode of death (however hastened in this case by the chloroform vomiting) was common. It was a question with him how far it might not have been wiser to cut through the vagina into the posterior cul-de-sac, and so remove the fœtus. Looking to the position of the placenta, it could not have been expelled by uterine contraction, and once the child removed and the funis tied, the latter would have wasted away, while the former, like an ordinary retained placenta, would have remained *in situ*, and no longer needed, become absorbed away. Such an operation appeared to him at this early stage more easy than the removal of fibroid through an incision made in the vagina, as practised by Altee, and successfully. But if this *modus operandi* was considered too dangerous, gastrotomy might have been attempted. He referred to a case of Dr. Greenhalgh's where it was practised in a lady, and in whom the operation succeeded completely, although the patient sank subsequently from shock. In this case, however, the operation was performed at a much later period of the pregnancy, and it was desirable, if done at all, that it should be done early; and before the relations with neigbouring tissues, and the formations of large vessels, had become extensive. Certainly in some cases of mistaken diagnosis the operation had been performed some three or four times, and if death had resulted in most of these cases, it was due more to the mismanagement after the operation, when the treatment of wounds in the abdomen was not so well understood as now, that ovariotomy or gastrotomy were commoner operations. In Dr. Hicks' case, the patient had died, and the puncture of the membranes and death of fœtus had not prevented the production of hæmorrhage internally, the common cause of

death in these cases. Did not the case therefore justify the experiment of one or other of the plans he (Dr. Routh) had suggested in any future case, recognised as extra-uterine at an early stage?

Dr. Graily Hewitt thought that the history of Dr. Hicks case showed the danger of interfering unduly with cases of this kind. Extirpation was not, he thought, a justifiable operation, but possibly simple punctures of the cyst might be unattended with risk. The history of these cases showed the propriety ot doing little.

Dr. Rasch mentioned a case of early extra-uterine pregnancy published by Professor Friedrich ('Virchow's Arch.' xxix, 3 and 4) in which four injections of a solution of morphia into the tumour through the vaginal wall allayed the great pain and arrested the further growth of the fœtus, which disappeared by resorption. This procedure being so simple and without any danger, Dr. Rasch was of opinion that it deserved to be tried before resorting to such heroic means as had been proposed to the Society. As the abdomen would often tolerate a dead fœtus for an indefinite time, all our endeavours, in early cases at least, ought to be to arrest the growth of the fœtus by killing it. The above-mentioned injections would also be free from the dangers of tapping the amnion.

Dr. Braxton Hicks in reply, assured Dr. Routh that the plans he had suggested had all been carefully considered before adopting the treatment. The plan of extracting the fœtus by incisions through the vagina, had been suggested by his colleague, but Dr. Hicks thought the risk so great, having suspected that the ovum had escaped from its original seat, that he declined to incur it, considering that there would be the greatest fear of hæmorrhage from any traction on the funis. Again, as to gastrotomy in this case being of use, the exceedingly low position of fœtus, and the thinness of the walls including it, rendered it very unlikely that it could be secured below, and highly probable that it was not in its original position, and also that the placenta was situated above. Indeed, the post-mortem examination showed that it was, so that the fœtus could not have been reached without displacement of the placenta. It was, it seemed to him, a clear rule in these cases to arrest the fœtal growth with the least possible risk to the mother, and this was the reason for following the plan he had. There were peculiarities in the case, the sac in which the ovum was originally placed being still open, but he attributed the death to displacement by vomiting, hastened it might have been by the death of fœtus and consequent softening of the ovular tissues. From a review of the whole case he did not see any plan of action less likely to be dangerous, and thought in these cases we had better be over-careful than the contrary.

REPORT ON THE ABOVE SPECIMEN.

By Dr. Barnes and Dr. J. Braxton Hicks.

We agree that the condition of the specimen coincides with the description given above. We consider that the cyst on the posterior aspect of the uterus on the left side originally contained the ovum, and that the latter escaped from the opening at its lower part, which opened into the recto-vaginal pouch of peritoneum. We are also of opinion that the pyoid serum, &c., contained in the cyst, was of recent origin.

Now, as the ovum sustained its vitality and growth after its complete expulsion, a question of some difficulty arises as to the manner in which this was effected. It seems to us that one of the following phenomena occurred :

1. That the cyst ruptured, the ovum escaping *at once* and *entirely*.
2. That the cyst ruptured, the ovum having been expelled from it by *a gradual process of extrusion.*

We are not aware of any case on record where it could be distinctly shown that the ovum had lived and grown some time after its complete expulsion from its original cavity, and therefore it is that this specimen possesses much interest.

If we adopt the *first* supposition, it is clear that the ovum, till it became adherent to the posterior wall of the uterus, must have derived its nutriment by endosmotic action, simply by the medium of the serous fluid of the peritoneum. This, at first sight, might appear a very scanty source of supply; but if we consider that the fœtal existence throughout is sustained by the endosmotic process, especially during the chorion period, this will not seem so surprising. But we must also remember the peritoneum has the power of very rapidly giving out its proper secretion, and also plastic lymph. Besides these points, it should be borne in mind that at the period at which the rupture of the cyst took place—viz., at the third or three and a half months of

pregnancy—the chorion villi situated all over the ovum had not probably become so completely useless, but that, under the circumstances, they might have assisted in the absorption of nourishment. The severe sudden pain and collapse of which the patient complained a week before coming under treatment give some support to the supposition of the sudden escape of the ovum.

But if we adopt the *second* explanation, we must suppose that the cyst having ruptured, the ovum was slowly extruded; that the portion outside, finding resistance below, bulged round the edge of the rent, so as to come into contact with the exterior of the cyst-wall, to which it then became adherent. If we suppose the placental portion of the ovum was situated at this point, we shall see that, while absorption of the inner part became detached, the outer part became attached, so that a considerable surface of placenta would remain constantly undisturbed during this kind of migrating process, and thus be capable of performing its functions. It may also be supposed that the chorion villi, not entirely effete, would be capable of assisting in keeping up the supply, as has been already pointed out.

While this second method of explaining the position in which the ovum was found will do away with the hitherto unknown circumstance, namely, that of the ovum in an advanced stage of development sustaining existence loose in the peritoneal cavity, yet at the same time it must be remarked that the position of the placenta, at the most remote spot from the opening in the cyst, offers some objection to the gradual emigration of the placenta.

There was no mark in the cyst to show where the placenta was attached originally. The detachment without hæmorrhage might perhaps, at first sight, appear a difficulty under either the above suppositions; but this will be much diminished when it is remembered that in all cases of extra-uterine fœtation the ovum is merely attached to the surface from which it derives its nutriment, so that, should the placenta be detached without rupture of its surface, no hæmorrhage could occur.

This case appears to us under either supposition to give considerable support to the old theory of ventral gestation, which has of late years been considered as almost, if not quite, exploded. Without entering into the merits of the cases quoted under that title, we may express our opinion that ventral conception is not more unlikely to occur than the case under our present consideration.

ON THE COMBINATION OF CHOREA WITH PREGNANCY.

By Dr. Bathurst Woodman,

RESIDENT MEDICAL OFFICER, LONDON HOSPITAL.

The concurrence of chorea with the pregnant condition is, I imagine, a not very frequent event. Certainly very little mention is made of it by obstetric authors, and as I have myself only met with two cases, I have been induced by our President, Dr. Barnes, to lay before you the main facts of one case, in order to elicit further opinions and experience, with a view to both prognosis and treatment. The first case which attracted my attention to the subject, was an out-patient of Dr. Down's, at the London Hospital, a primipara, in whom chorea supervened on a six weeks' pregnancy, from fright at seeing her husband, as she thought, killed by an accident. She soon recovered from the convulsive movements, under the use of arsenic and nourishing diet, but labour came on at eight months, and the child had a cleft palate, hare-lip, and webbed fingers. As Dr. Down intends to publish full details of this case, I pass on to the more recent one, which is the subject of this paper, and which in some particulars affords a considerable contrast.

Caroline S—, æt. 18, an engineer's wife, residing at Bow, was admitted an in-patient, under Dr. Fraser's care, on the 3rd January, 1865, for acute chorea. She was then about six and a half months pregnant with her first child,

and had had involuntary jerking movements, chiefly of the head and upper extremities, for nearly three months. Her mother states that she suffered only from measles and whooping-cough up to the age of seven, when she was first attacked by chorea, "she thinks from fright." From this she was never free for more than a month or two, till a little after she was thirteen, or in point of fact, till her first menstruation. At eight years old she had something like rheumatic fever, and soon after that, what her mother calls "typh*us*," but which was evidently "typh*oid* fever." This was not till a full year after the first attack of chorea. She never had scarlet fever. From the age of puberty till her present seizure she was entirely free from choraic movements—an interval of five years. No reason is known for their recurrence. She is a thin, delicate person, small in figure, of light brown hair, and eyes of nearly the same colour; was anæmic, and much impressed with dread of impending danger, as she was told by some of her friends to expect convulsions in labour. She had a distinct systolic bruit, heard at the apex of the heart. Her bowels were regular, tongue clean, and appetite fair. The urine was of specific gravity 10·20, and contained no albumen, but about two grains of sugar to the fluid ounce (a condition, which in common with Dr. Goolden, I hold to be not unusual in chorea); in this instance, several independent tests were relied on for the detection of the sugar. The fœtal tic-tac was only heard once or twice, owing to the unusual loudness of the placental bruit, which was heard all over the abdomen anteriorly, especially below the navel. (It was afterwards found that the placenta, which was very small, was attached to the uterus anteriorly, within the "dangerous zone," but not amounting to placenta prævia.) She was first treated by steel, and afterwards (by Dr. Barnes) with the diphosphate of zinc and iron, but in conformity to the too severe rules of the hospital, was made an out-patient at a
night's end, at which time Fowler's solution was giver

About the end of February the chorea quite l
On March 22nd, her mother came to me in great

stating that the patient had been in labour twenty-one hours, and that the midwife thought there was "something wrong." I accordingly attended, and found the child's head, which was rather more than usually developed as regards bone, tightly wedged in the inlet of the pelvis, and presenting in the first position (of Naegelé). The os uteri was well dilated, but in spite of strong pains, no progress was made, and I therefore pushed up the head a little, introduced Dr. Barnes' long forceps, and in twenty-five minutes delivered her of a full-sized, perfectly formed, and living female child whose only imperfection, if it be one, was a little "tongue-tie."

She flooded a little the first two days, but had no choraic movements till four days after labour, when there were slight twitchings of the right hand, which she states "is weaker than the other." These movements only lasted three days, and she has now apparently recovered well, in spite of sore nipples, which threatened mammary abscess, but succumbed to tannic acid. The child has had no chorea yet. The mother has none now, but the mitral bruit persists, and she is still rather anæmic. The points of interest in the case are, I think, the following. First, the priority of the chorea to the rheumatism; next, its disappearance when puberty became established; its reappearance before she "quickened;" its recession at the end of the eighth month of pregnancy, and the slight renewal of the movements after the flooding consequent on labour.

I confess, that for myself, seeing as I do about 200 cases of chorea amongst in- and out-patients at the London Hospital in the course of the year, and finding the majority badly nourished, and anæmic, I am inclined to believe that these movements are chiefly reflex, and connected with the sympathetic nervous system. And notwithstanding the favorable issue of this case, so far, I think the complication of chorea with pregnancy is an event of itself calculated to cause anxiety, and to call for prompt measures to remove all sources of irritation, and to improve, as far as lies in our power, the general nutrition of the patient.

I have since heard of another case of four to five months in a primipara, which ceased, under tonics, a month before delivery. She had no unusual symptoms. (Dr. Lever published five cases in 'Guy's Hospital Reports,' vol. v.)

The case detailed at length in my paper has since had a subacute abscess in each breast, but no return of the chorea. She and the child are both doing well.

CASE OF OVARIAN DROPSY—OVARIOTOMY—RECOVERY.

By H. W. Sharpin, F.R.C.S.,

SURGEON TO THE BEDFORD GENERAL INFIRMARY.

C. S—, a slightly made, healthy-looking woman, æt. 54, was admitted into the Bedford General Infirmary, on July 16th, 1864, with an enormously enlarged abdomen, dull on percussion, and yielding a distinct sense of fluctuation, uniformly perceptible over its whole surface; its circumference at the umbilicus was forty-one inches.

She stated that she was married when twenty-three years old, had one child at twenty-four, and another at twenty-six, each born at the full term of gestation, and confinements in either case natural. After the age of twenty-six she never became pregnant, but enjoyed good health, and was quite regular until forty-five or forty-six years old, the catamenia becoming then irregular, ceased entirely at forty-eight. About the time of becoming irregular, which would be eight or nine years since, she first perceived a "lump" within the abdomen, in the right iliac region, of the size and shape of a goose's egg; it was painless, would roll over to the left upon her turning on that side, and continued to be readily felt for a few months; afterwards, it was not to be defined in consequence of a general swelling of the abdomen.

The abdominal enlargement steadily increased, but during the last few months the rate of increase became much greater than previously, and the distress to the patient in breathing and walking proportionately augmented. Had never been tapped, nor undergone any treatment for the reduction of her size.

Upon admission, July 16th, tongue was clean, pulse not very strong, about 70. Bowels rather constipated; urine healthy. She was put on a liberal diet, her bowels were got into a less confined state, and on July the 29th I operated upon her, without chloroform, for the removal of what I had diagnosed to be a large ovarian cyst.

The temperature of the room being about 76°, and the patient's bladder emptied, she was placed in a semi-recumbent position upon her back, with her legs hanging over the foot of the bed, and a jack-towel applied as a bandage round the abdomen, with its ends crossed at the back, and each in the hands of an assistant. Commencing two inches below the umbilicus, an incision was made, between three and four inches in length, downwards in the mesial line through the linea alba; this brought in view what appeared to be the wall of a cyst, upon thrusting into it a large trocar a clear straw-coloured fluid escaped, and with the tightening of the bandage the cyst itself, as it became empty, protruded through the wound; the last portion only did not protrude in this way, but seemed somewhat adherent, and had to be drawn forcibly out; it was found, however, that there was no adhesion, this part of the cyst having become merely wedged into the cavity of the pelvis.

As the cyst escaped the edges of the wound were kept closely together, the pedicle was tied tightly with a stout silk ligature, and cut across about half an inch above the constricted portion; it was drawn to the bottom of the wound, and there retained outside the peritoneal cavity by winding the ends of the ligature round a steel hare-lip needle, which had been made to transfix and bring together the edges of the wound immediately above it; two other needles were used for bringing together the remainder of

the wounds, and to give additional support long strips of adhesive plaister were used. The abdomen was then tightly bound round with a flannel bandage, a large pad of lint being placed in the hollow at the epigastrium. The patient apparently suffered very little from pain or faintness during the operation, and her pulse was very slightly affected. Upon measuring the quantity of fluid it was found that three gallons had been drawn off; the wall of the cyst was about the thickness of an ordinary urinary bladder, very vascular, some of the vessels being as large as a goose quill.

One grain of opium was given immediately after the operation, and ordered to be repeated at night. A catheter to be passed night and morning, and iced barley-water the only food allowed.

She was in much pain in the abdomen the first night, and vomited two or three times. The pulse was hard, 92. Another dose of opium (Tinct. Opii ♏xxx) was given. On the following morning, July 30th, the pain had gone, she expressed herself as "very comfortable," and was perspiring freely. Ordered Tinct. Opii ♏xxx, nocte maneque.

On the morning of August 1st, she had continued to progress most favorably, and, in addition to the barley-water, tea and bread and butter, with an egg, were allowed; but on the evening of that day some bloody mucus escaped upon the withdrawal of the catheter.

On the 3rd, the silk around the pins was changed, and the wound, which looked very healthy, well washed; the remains of the pedicle sloughing.

On the 4th, a mutton chop and half a pint of ale ordered.

On the 6th, all the pins removed, wound healthy; two chops and one pint of ale allowed.

On the 9th, there had been no action of the bowels since the operation, eleven days; a castor-oil injection was used, but with no result, the injection itself being retained. No further steps were taken to procure an action of the bowels. The urine was on that day passed freely and perfectly healthy in appearance, but up to that period it had been

drawn off night and morning, and a little blood and bloody mucus had always accompanied the last ounce or two. Pedicle completely detached.

On the morning of the 10th the patient appeared remarkably well, but on the evening of that day she was suddenly seized with a short incessant cough, which at the time of my seeing her, had continued uninterruptedly and without a moment's intermission, for upwards of half an hour. She had become much exhausted, and most serious results threatened, but upon swathing the lower part of the chest very tightly with a bandage, the cough immediately ceased. After this, the patient made a slow but steady recovery, feeling very faint occasionally, especially upon any slackening of the bandage round either the chest or abdomen. The bowels were not moved until August the 13th, fifteen days after the operation; after this time they were moved regularly every day without medicine. Living at some distance, she was not discharged until November, since then I have seen her twice. She is now, March 17th, 1865, quite well and able to walk about with comfort. She feels a little weakness at the lower part of the body, but this is gradually lessening.

Remarks.—Two points in this case are worthy of note; one, the freedom of adhesions of the cyst, and the other, the serious symptoms which after the operation seemed to threaten an unfavorable result, and which were solely due to the removal of the pressure which had been exerted, perhaps for some years, upon the lungs and bladder, by this enormous dropsical ovary. It is impossible to know to what extent the thoracic and abdominal viscera may in this case have been displaced and compressed by this cyst, with a capacity of three gallons; but the bloody purulent matter from the bladder, and the violent and incessant coughing, which last really foreboded immediate danger to life, but stopped directly upon the application of a tight bandage, show most plainly that a portion of the bladder and the lungs had been compressed, and that the

serious symptoms were the consequence of a removal of the pressure of the ovarian cyst from these organs. With regard to the non-existence of adhesion, the mobility of the tumour in its early stages, and subsequently the absence of all inflammatory symptoms and surgical interference, led me to hope and even to expect that such was the case, and certainly influenced me in undertaking the operation.

The fact of finding that no adhesions did exist, and the consequent easy removal of the cyst should, I think, make us hesitate in any case of ovarian dropsy to tap or to use other means, which might possibly excite inflammation, if ulterior measures be contemplated for the extirpation of the diseased ovary.

CASE OF HERNIA CEREBRI AND HERNIA UMBILICALIS, WITH ATTACHMENT OF THE FŒTAL MEMBRANES TO THE SCALP.

By Thomas Hawkes Tanner, M.D.

The monster of which the accompanying sketch (Pl. V) is a representation, was expelled from a patient who had been under my charge some months previously. The fœtus presents such a rare and remarkable combination of deformities as to justify, in my opinion, a place in the 'Transactions' of this Society. The history was as follows:

Mrs. —, æt. about 21, had previously had two children, the monster being the third. In her first labour, at full term, she was delivered by instruments, and made a very tedious recovery, owing to a severe attack of vaginitis which followed. Her second labour occurred on the 22nd March, 1863; and as there was considerable difficulty to the passage of the child, Mr. J. F. Clarke was sent for by the midwife in attendance. This gentleman, finding the vagina

obstructed, asked for my assistance. On examination, it was clear that the vagina was so occluded by bands and adhesions—the result, no doubt, of the previous vaginitis—that delivery of a living child by the unassisted efforts of nature, was evidently impossible. Fortunately, however, the child was dead, so that one was spared the pain of perforating, which was essential to delivery, prior to which it was necessary to divide the cicatrices, which I accordingly did, and without further difficulty delivered by craniotomy.

The third pregnancy resulted in the birth at the seventh month, of the little monster figured in the accompanying sketch, Plate V, which represents it about three-quarter size. It was dead when born. There was found to be a hernia of the umbilicus, about as large as a small hen's egg. A similar displacement of the brain through an opening in the left temporal and frontal bones; while firmly adherent to the scalp, about the same situation, indicating the probability of some adhesive inflammation in the early months of gestation as the cause of the malformation, was a portion of the fœtal membranes. The fœtus had evidently been dead some little time; it was much shrunken and emaciated, and presented a sort of blighted appearance.

LARGE FIBROUS TUMOUR OF UTERUS; SPONTANEOUS SLOUGHING; DEATH FROM PERITONITIS.

By J. Braxton Hicks, M.D., F.R.S.

Mrs. F—, æt. 40, married; sterile. Had been for many years suffering from metrorrhagia of severe character, whereby her appearance was always anæmic. She had also suffered from tertiary syphilis during many years.

Till within a short time of the sloughing of the tumour the uterus was as large as the sixth or seventh month of

Dr. Westmacott del. ¾ size. W. West, lith.

pregnancy. A year and a half since, it was attached to the uterus by a very broad base, but I hoped that some day it would become polypoid, and perhaps capable of removal. However, she came to me about ten days before her death, very ill, having had a brown and very offensive vaginal discharge for three weeks; no appetite during that time; pulse at that time 120, small; tongue as usual, preternaturally clean; much pain over lower part of abdomen. I found a large tumour in vagina, reaching from perineum upwards as far as one could reach above the brim. She was taken into Guy's Hospital, the vagina washed out for a few days with Condy's fluid, the bowels emptied; and about four days after, Mr. Savage (clerk) removed with the wire-rope écraseur as much of the mass as could be reached. After this was removed from vagina, the os could then be found distended by the pedicle and a small portion of the polypoid mass. It was so soft that it could only be seized by forceps, and this instrument was not able to bring it down, as it broke away so readily. However, I brought away by it all the part not in cervix, which appeared only like the sloughing pedicle.

The vagina was washed out with Condy's solution twice a day. For two days she improved, but at that time she had severe pains in uterus, like labour-pains, with no tenderness. Next day, with some slight hæmorrhage, she expelled a large, very soft, pulpy mass, at first sight like a clot; but on examination it was of distinctly fibrous texture, and was, indeed, clearly a portion of the fibrous tumour. After this she became very low, complained of much peritoneal pain. After fluctuating in this state for two days, with evident peritonitis, she became suddenly worse, and shortly died.

The post-mortem examination showed acute peritonitis everywhere. The uterus was enlarged to four or five times its normal size. On section, the walls were found gradually thickened towards the fundus, where existed a cavity of from two and a half to three inches diameter, the base of which extended to almost, if not quite, the peritoneal membrane, the

walls all round the cavity being from one and a half to two inches thick. The whole of the surface of this cavity, which was evidently the bed of the tumour, was ragged and sloughy. There were fatty liver and kidneys.

JUNE 7TH, 1865.

DR. BARNES, President, in the Chair.

Present—49 Fellows, 15 visitors.

The following gentlemen were elected Fellows of the Society:—Dr. D. D. Brown, Aberdeen; Dr. E. Charlton, Dartford, Kent; Dr. J. Paterson, Glasgow; G. F. Gwynn, Esq., Westcroft House, Hammersmith.

The President exhibited a large fibroid tumour, which had been expelled spontaneously from the uterus several weeks after labour. The structure consisted of fibre-cells, resembling those of the muscular wall of the uterus. The patient was actually under care for vesico-vaginal fistula.

TWO CASES OF HYDATIDIFORM DEGENERATION OF THE CHORION, ASSOCIATED WITH ALBUMINURIA.

By W. BATHURST WOODMAN, M.D.

CASE I.—*Cystic Disease of Chorion; Albuminuria and Heart-disease.*

M. K—, æt. 36, a married woman, was admitted in June last (1864) an in-patient of the London Hospital, under care of Dr. Parker. She has had four children; says she miscarried at six months, about a year ago. The cata-

menia were regular for about six months afterwards, but have now been absent six months. She thinks she is pregnant. When admitted, she was of enormous size, the abdomen being greatly distended with fluid; she had also some general anasarca, most marked in the lower extremities and labia pudendi. There were distinct cardiac murmurs with the systole at both base and apex. Her urine was scanty, and generally albuminous; but I failed to find any casts. On the 9th July she began to flood, and this continued more or less for eight days, when, with "labour pains," she suddenly gave birth to a mass of from two to three pounds' weight of "hydatids," varying in size from that of a large gooseberry to that of a pin's head, but the size of a white currant about the average. With these was some degenerated, spongy placental tissue. They were most carefully examined for traces of echinococci or any other parasite, but none were found. Their structure was evidently that of cystic disease of the chorion, the only point of special interest being that most of them had undergone fatty degeneration, so that the contents of many were quite oily. Some contained blood, others only albuminous fluid. The os uteri interior had a rugged hard surface, and felt as if fissured. With saline diuretics and good diet, the dropsy disappeared. Her liver was apparently diminished in size. She was, no doubt, too fond of stimulants.

CASE II.—*Cystic Degeneration of the Chorion, with Albuminuria; Death.*

E. H—, æt. 24, single; a servant in a clergyman's family, applied to Mr. Stormont, of Cheshunt, with a sore-throat, on the 8th and 9th March last (1865). He found the tonsils and pharynx swollen and reddened, and diagnosed the affection as scarlatinal (scarlatina was epidemic there then). He advised her to go to bed, but she left her service instead, and was lost sight of. On the 4th April she was admitted into the London Hospital under Dr. Parker, suffering from general anasarca, especially of the lower extremities, which were almost bursting, œdema pulmonum, with general dyspnœa, and some bronchitis. She

states that from the middle of December last (1863) till the end of February the catamenia were absent. From that time till now (six weeks) she had almost continual flooding. A little before that she says she had pain in the back, and had frequently to get up in the night-time to pass water.

She does not herself know that she had scarlet fever. She had a child eight years ago; had no dropsy then, and not much now till the flooding. "She has now an abdominal tumour equal to *seven months' pregnancy* at least, although by her own statement she can only be about three and a half months pregnant. She has a brown line on the abdomen, and numerous lineæ albicantes on belly and upper part of both thighs. Her breasts are large, have very large and wide areolæ, and the follicles are evident; but the breasts are not very plump, indeed are rather flaccid, and the venation is less than one would expect. The os uteri is reached with difficulty, but is patulous, has a velvety feel, and is filled with some soft spongy body (I thought it placental—Was it a blood-clot?) I failed in getting ballottement. There is a very distinct *bruit placentaire* heard widely, but best an inch and a half obliquely to left of umbilicus." The fœtal heart was never heard.

Her urine was rather scanty; its specific gravity generally about 1020. It contained an enormous quantity of albumen, and a few granular and epithelial casts, together with a kind of general moulting of nearly all the genito-urinary tract; young and granular epithelium from various parts of kidney, ureter, bladder, urethra, and vagina, being present in great quantity. Half a drachm of urine yielded only ·25 c.i. of nitrogen, or a quantity equivalent to only about 2½ grs. of urea per fluid ounce. Purging and rest relieved much of the œdema, and compound cascarilla mixture relieved the cough, &c.

She was transferred to Dr. Barnes's clinique on the 13th April. Early on the 14th flooding set in, pains like labour came on the same night, and early next morning (15th) she commenced passing bunches of so-called hydatids, with a good deal of hæmorrhage. It was impossible to introduce

the whole hand into the uterus, so plugging was first adopted, and afterwards ergot. The same evening she passed a wash-hand-basinful (3—4 lbs.) of the same sort of hydatids, the larger being equal to grapes, the smallest a pin's head, the average a pea. Some of them had slender pedicles, others were closely attached. The microscope showed no trace of echinococci, but just the chorion-villi structure shown in Paget's plate. She was much exhausted by the hæmorrhage, and got vomiting on the 16th and 17th, with great dyspnœa and retention of urine, a pint of which (sp. gr. 1015) was drawn off (ʒss of which yielded ·3 c.i. nitrogen = 2·8 grs. urea per ounce nearly). It still contained albumen, but in less quantity than before.

She died at 8 p.m. on the 18th instant, apparently of syncope.

Post-mortem examination (twenty hours after).—Body still rather œdematous, and had a very blanched look. The lineæ albicantes, brown line, areolæ, &c., have been described before. The breasts still contained milk. The pericardium contained quite 6 oz. of straw-coloured serum. The mitral valves were a little thickened, and not quite competent. (Mitral regurgitation was diagnosed in life.) Both sides of the heart were partially full, and contained soft yellowish clots.

The lungs were a good deal congested at their bases, but were otherwise healthy, and contained a good deal of air. The liver was pale, yellowish, and rather soft; its acini were unusually well marked, and a good deal of serous fluid could be squeezed from it. The kidneys were very large, and about twice the average weight of these organs, like white marble, with arboriform vascularity. They were too soft, their cortical substance diminished, but the pyramids unusually well marked. The spleen soft and diffluent; a good deal of turbid, flaky serum in the abdominal cavity. There was purulent fluid in the pelvis. Both ovaries large (size of oranges), studded with cysts, one or two of which in each ovary contained blood, and one or two had apparently burst into peritoneal cavity. The Fallopian tubes

contained cord-like casts of fibrinous material. The uterus —size of small fœtal head—was rather flabby; its walls were about an inch thick, covered with a kind of spongy mass (as if the hydatids were attached all round), and were much discoloured. The sinuses would admit a large goose-quill. Its cavity would contain about six fluid ounces.

N.B.—It will be observed that in the first case (M. K—) the woman lived with her husband, and thought herself to be pregnant.

In this case (E. H—) the girl admitted sexual intercourse, and thought herself to be pregnant also.

Dr. Graily Hewitt took a different view as to the nature of the case from that held by Dr. Woodman. The condition of the chorion present in these cases of hydatidiform ovum was, as he had some time ago shown, rather to be considered as an accident than a disease. He believed it resulted simply from continuance of growth of the chorion villi after death of the embryo. In several cases he had known, the death of the embryo was produced by mechanical agencies; symptoms of abortion occurring, but without expulsion of the ovum, the membrane of which remained in the uterus and continued to grow. His opinion had received adoption by very distinguished observers. It was incorrect to employ the term "hydatids of the uterus;" this only tended to perpetuate erroneous ideas on the subject; the so-called hydatids were merely serous bag-like entanglements of the stems or other parts of the chorion villi. The question as to the connection between albuminuria and occurrence of hydatidiform ovum was one on which he would express the following opinion:—In cases of albuminuria abortions are liable to occur in consequence of imperfect nutrition of the fœtus. The fœtus dies, and as a result of this death (the ovum remaining still within the uterus) the chorion villi undergo the hydatidiform degeneration.

A THIRD CASE OF HYDATIDIFORM DEGENERATION OF THE CHORION ASSOCIATED WITH ALBUMINURIA.

By Robert Barnes, M.D.

The coincidence of hydatidiform degeneration of the chorion with albuminuria in the two instances recorded by Dr.

Woodman appears to be deserving of further study. I am therefore induced to append a third case, which came under my observation.

In June, 1853, I was consulted by my then colleague at the Western General Dispensary, Mr. Gregory Forbes, concerning a case of dropsy with uterine discharge. The following history of the case is chiefly from Mr. Forbes' notes:

A. W—, æt. 42, has had eight children and three abortions. When she applied to Mr. Forbes, on the 17th of June, she had considerable anasarca of the legs, which commenced three weeks ago. For twelve months she has had sickness and tenderness in the stomach, with occasional "vomiting of phlegm and wind." Has headache when she lies down, and is drowsy. Face pale. Tongue yellowish fur. Urine reported scanty and high coloured, sometimes very pale, and not more than a teacupful in quantity daily. Pain in passing water at the bottom of the stomach. Two months suffered a burning pain in the region of the womb. Great thirst. The last child is three years old; it was suckled two years, which reduced the mother's strength. She had an abortion at the third month, a year ago. Since then menstruation has been regular till Christmas last. From that date there has been a little discharge now and then. For the last two months there has been a continuous discharge of coloured fluid. The pulse is rapid and feeble. On the 18th, whilst in bed, she felt a vaginal discharge, and on getting up passed a large quantity of blood. This left her very anæmic; pulse 108; headache. No pain preceded the hæmorrhage; she thought it was a miscarriage. She said she believed she had quickened, and felt fœtal movements; there is a tumour in the seat of the pregnant womb, prominent, extending more to the right side and upwards to the umbilicus, firm and elastic, tender on pressure. She says it is smaller since the hæmorrhage. The os uteri is the size of a shilling. The substance of the cervix, just beyond the orifice, was rigid. No placental murmur or fœtal sound could be heard.

She reminds us that she had dropsy in the legs with her first child, and "then passed blood for water."

On the upper part of the left side of the tumour there is a small mass the size of a walnut, which slips about under the fingers; it is very sensitive when compressed. The breasts are quite flaccid. The os opened more in the afternoon; a little oozing went on. Dr. Barnes suggested galvanism to the uterus. This answered well; the uterus contracted, and Mr. Forbes was enabled to bring down a bunch of hydatids. The vagina was then plugged, and the abdomen bandaged. At night the plug was removed; more hydatids came away, with slight oozing; the uterine tumour was much smaller. The patient was very blanched and weak. She took eggs, brandy, tincture of ergot, and laudanum.

19th, 9 a.m.—Has passed a good night. The abdomen sore on pressure; another small quantity of hydatids was removed; this caused uterine contraction. A shivering fit followed. At 3 p.m. Mr. Forbes was sent for in haste; another mass of hydatids had been passed; it had been expelled suddenly with pain like labour-pain. The womb now felt firmly contracted, the size of a cocoa-nut; pulse 132; prostration; abdomen tender; vomiting. At 8.30 p.m. semi-stupor, retching and sighing; pulse 132, very feeble; some rigidity of the arms. Three ounces of bloody urine was drawn by catheter. She died the same night.

Sectio cadaveris (next day).—Abdomen tympanitic, integuments becoming emphysematous. Four or five ounces of turbid serum, with flakes of lymph, in pelvic cavity. Intestines very pale. Uterus the size of a cocoa-nut; peritoneal coat and whole structure very pale, walls flabby. There was a fibroid tumour, the size of a large orange, in the right wall, near the neck. This tumour she had pointed out to her husband as the child's head. The cavity contained a brownish flocculent membrane, half detached from the uterus, but no hydatids. The left ovary contained small cysts. The kidneys were large, pale, and considerably advanced in fatty degeneration.

The following is my description of the placenta:—It was almost entirely converted into cysts, some as large as a walnut. The cysts were only held together by shreds of

chorion, fatty looking, and easily lacerable. The chorion-membrane was full of granular fat, and showed no trace of vascularity. The walls of the cysts were composed of delicate fibrous membrane, with nuclei interspersed, and some bright fat-granules. The decidua was a loose shred; it consisted of elongated fibres and elongated nuclei, somewhat fatty.

ON DYSMENORRHŒA, METRORRHAGIA, OVARITIS, AND STERILITY, DEPENDING UPON A PECULIAR FORMATION OF THE CERVIX UTERI; AND THE TREATMENT BY DILATATION OR DIVISION.

By Robert Barnes, M.D. Lond.,

OBSTETRIC PHYSICIAN, AND LECTURER ON MIDWIFERY AND THE DISEASES OF WOMEN AND CHILDREN, ST. THOMAS'S HOSPITAL; EXAMINER IN MIDWIFERY, ROYAL COLLEGE OF PHYSICIANS; ETC. ETC.

The association of painful menstruation, uterine hæmorrhage, and sterility, with a peculiar formation of the cervix uteri, has been generally recognised for some years. Indeed, this fact in pathology appears to be simply a recovered legacy from the most remote epoch of medical history. Dr. H. G. Wright has, in a late number of the 'Lancet,' cited a passage from Aëtius, in which not only is the dependence of sterility upon a contracted os uteri pointed out, but the supposed modern treatment of dilatation by compressed sponge-tents is also described. The late Dr. Macintosh, regarding this association as one of cause and effect, sought by mechanical means to alter this peculiar formation, in order to cure the attendant functional disorders. Professor Simpson, in 1844 ('Edinb. Monthly Med. Journ.'), professed the same opinion, and advocated a similar principle of treatment. Since then various practitioners have pursued the subject, and various have been the conclusions

arrived at, both as to the primary fact of the dependence of painful and profuse menstruation and sterility upon any peculiar formation of the cervix uteri, and also as to the secondary question of the particular part of the cervix which is the seat of the mechanical obstruction. A clear understanding, then, as to the peculiarity of structure found associated with the functional disorders described, is an essential condition to the successful investigation of the important questions of pathology and treatment.

Professor Simpson appears to have concluded that the abnormity consisted in a strictured condition of the os internum uteri; and he sought to remedy this by various forms of bougies and sponge-tents, and afterwards by incisions made by means of a *bistouri caché*. My friend Dr. Henry Bennet, however, adduced, as I think, conclusive anatomical and pathological observations to prove that the *os uteri internum* was very rarely the seat of any obstructive constriction. A narrowing at the isthmus dividing the uterine cavity proper from the cervical cavity, so marked as to oppose the ready passage of the uterine sound, is normal and almost constant. This is a point of exceeding importance to establish, because, if the os internum be not the seat of difficulty, it becomes unnecessary to expose the patient to the pain and dangers attending upon forcible dilatation or incision of that part.

Some authors have found the cause of obstruction to consist, not in stricture, but in bending of the cervix upon the body in such a manner as to close the canal at the point of flexure. This is certainly sometimes true; but I am disposed to think that even Dr. Marion Sims has somewhat exaggerated the importance of flexion as a *primary* factor in the production of dysmenorrhœa. The condition that prevails most frequently seems obvious enough. If a woman has suffered long from painful menstruation and metrorrhagia, and has been married some years without pregnancy, it may be predicated with great confidence that the neck of the uterus projects in an abnormal degree into the vagina; that its form is conical; that the os internum is a small

round orifice, barely admitting the uterine sound; and that probably there is deviation of the cervix backwards or forwards, or to one side. This form of cervix has been aptly described by Ricord as the "*col tapiroïde.*" It is, no doubt, congenital, and may be traced back to imperfect development. It is sometimes associated with imperfect development of the body of the uterus and of the ovaries; but this association is certainly not a necessary one. In the majority of instances the ovaries perform their function, irregularly, it is true; and pregnancy frequently occurs after the error of formation of the cervix is corrected.

Another circumstance to be noted is the rather frequent association of this peculiar form of cervix with a short vagina and general defective development of the pelvic organs. In figs. 1, 2, 3, 4, I have sketched the common forms of the conical vaginal portion of the uterus. The vaginal portion may project into the vagina from half an inch to one inch, an inch and a half, or even two inches. This excessive pro-

Fig. 1.

Fig. 2.

jection into the vagina may be due to a preternatural hypertrophic elongation of the lower part of the cervix; but I believe it is commonly due to the reflection of the fundus vaginæ taking place at a higher point of the cervix than usual. In the ordinary construction the cervical canal communicates freely with the vagina by an open transverse fissure, inclining, indeed, to a circular form in the virgin. The form of the cervical cavity is thus a flattened cone or funnel, of which the base is open. The vaginal

portion projects as a flattened semisphere scarcely half an inch into the vagina, the vagina being reflected off from the cervix a little above the level of the os externum. In figs. 3 and 4 the vaginal portion is a cone, the apex projecting nearly an inch in the vagina, and the vagina being reflected off nearly on a level with the os uteri internum. Instead of the natural free communication between the cervical cavity and the vagina, the os externum is so contracted as to form a sensible obstruction. Indeed, sometimes the ordinary uterine

Fig. 3.

Fig. 4.

sound can be passed only with difficulty; and I have known the occlusion to be complete at times, requiring some little force to break down a thin membranous septum formed at the orifice. As soon as the os externum uteri is penetrated by the sound, it is usually found that the point enters into a sufficiently capacious cervical cavity. This cavity, in fact, is exactly spindle-shaped; it narrows again towards the os uteri internum, which is, as Dr. Henry Bennet has shown, naturally a small opening. In cases of protracted suffering from the dysmenorrhœa attending the peculiar form of cer-

vix under consideration, I have, however, generally found that the sound passes through the os internum without difficulty. It is by this observation that I have come to the conclusion, already mentioned, that in some cases the excessive projection of the vaginal portion is simply due to the vagina being reflected off from the cervix at a higher level than usual. In such cases the introduction of the sound to the fundus uteri shows the entire length of the organ to be normal.

The seat of the obstruction, then, I believe to be almost invariably at the os uteri externum. The obstruction is due chiefly to the small round os itself; partly to the pointed elongated form of the lower part of the vaginal portion, and partly to an unusual rigidity of structure of this part, which impedes the expanding action natural to the healthily formed os uteri.

With this coarctation of the os externum uteri, and undue projection of the cervix into the vagina, we might almost reason out most of the consequences which observation has detected. Some of them I will briefly describe. The narrowing of the vaginal orifice of the womb will, as has been often described, cause obstructive dysmenorrhœa. This is, indeed, sometimes so marked as to resemble retention of the menstrual fluid from complete occlusion. There is a partial occlusion, and the same symptoms, only less in severity, follow. The ovarian excitation of menstruation causes engorgement of the uterine mucous membrane; blood is effused; it cannot escape readily, and whilst fluid; it tends to accumulate in the uterine cavity and in the cervical cavity, and sometimes to form coagula. The blood so gathering and pent up in the uterus causes efforts at expulsion, betrayed in spasms or uterine colic. These pains are constantly likened to labour-pains; they recur at distinct intervals of from five to fifteen minutes, are extremely severe, and are commonly partially relieved on the discharge of a quantity of blood or coagula.

This is often the character of menstruation in girls having his formation, from the very establishment of the function;

but sometimes menstruation only assumes this painful character after the lapse of some time.

The next consequence is periodical congestion beyond the normal degree of the ovaries and uterus. Preternatural congestion seeks relief in hæmorrhage. The mucous membrane of the Fallopian tubes and uterus pours out blood copiously. Hence we have metrorrhagia or menorrhagia, in addition to dysmenorrhœa. The patient is distressed by the recurrence of the menstrual flow after intervals of two or three weeks only, and by its lasting for a week or ten days.

A secondary consequence—I am persuaded not an infrequent one—is an oozing of blood from the abdominal end of the Fallopian tubes and from the surface of the congested ovaries. This is a form of retrò-uterine hæmatocele of which I have seen several instances in young girls. Symptoms of shock announce the outpouring of blood into the peritoneum, or in the cellular tissue of the broad ligaments; intense pain in the abdomen and pelvis, fever, announce the reaction and peritonitis. As in almost every instance of retrò- or peri-uterine hæmatocele, a simultaneous escape of blood takes place externally.

Attendant upon repeated congestions, ovaritis may follow, entailing plastic adhesions between the Fallopian tubes and ovaries, and limited pelvic peritonitis. These adhesions may become a cause of sterility, and will, I believe, sometimes induce atrophy of the ovaries.

All these results may occur in single women. When women so suffering marry, the symptoms set forth are often much aggravated in severity, and new evils add to their distress.

1. *Sterility* is an almost constant condition. Occasionally one meets with examples of the conical cervix with small os with the history of a childbirth some years previously, and more frequently with an account of having suffered abortion. Strict inquiry will generally throw doubt upon the reality of the abortion. The profuse flooding and discharge of clots interpreted by the patient as evidence of abortion are often

nothing more than the metrorrhagia characteristic of the uterine obstruction. Where impregnation takes place, it usually does so in young persons early after marriage, that is, before the further disorders, which we shall presently notice, have had time to be developed.

2. *Cervicitis interna et externa* and *endometritis* are amongst the first consequences of marriage. The periodical engorgements of menstruation easily pass into subacute and chronic inflammation, chiefly affecting the mucous membrane lining the cervical cavity and the vaginal portion. The secretions resulting from this inflammatory action find difficult exit from the cervical canal. Hence there is increased, often constant, pain. Conjugal relations become almost intolerable. It is common now to find a highly vascular state of the cervical mucous membrane; the small portion seen just inside the minute os is deep-red, angry looking. There is loss of epithelium round the os. The introduction of the sound easily causes bleeding. At first the discharge is chiefly albuminous; afterwards it becomes muco-purulent and even sanguineous, and by its abundance entails serious constitutional debility.

Not infrequently, vaginitis follows, chiefly affecting the upper part of the canal. This I have several times found so intense as to produce vaginismus, and render sexual relations impossible.

3. Whether or not the inflammation described be produced, *deviations of the projecting vaginal-portion* are very common. The most ordinary form is flexion or curving of the cervix forwards. Sometimes it is driven backwards. Lateral deviation to the right or left is often observed. In fact, the excess of vaginal portion is equivalent to a foreign body in the vagina. It is thus constantly liable to injury in the shape of inflammation and displacement.

I believe flexions of the cervix upon the body occur far more frequently in this way than as the result of a fibroid body growing in the wall of the body of the uterus, as represented by Dr. Marion Sims. The deviation really belongs to the cervix, and not to the body. Whenever deviation

takes place the prospect of impregnation is still further impaired. The minute os externum is thrown aside, and there is stricture by angulation at the seat of the os uteri internum.

I have notes of a case which shows in a striking manner the severity of the symptoms sometimes produced. A young lady had been married two years without pregnancy. Since marriage she had suffered from metrorrhagia, and several attacks considered to be, and treated as, peritonitis. During the last six months she has had a constant sense of swelling with pain in the left ovarian region; vomiting attends the pain. This has been relieved by leeching. When I saw her, metrorrhagia had continued six weeks without cessation. Great prostration was present, with irritative fever, reminding me of pyæmic puerperal fever. I found a small conical cervix, with an os so minute that it required considerable pressure to introduce the uterine sound; deviation of the cervix to the left; defined tumefaction and pain in the left ovarian region. I inferred that the constricted os externum, impeding the flow of blood from the uterus, led to the formation of coagula in the cavity; that these coagula were broken up by decomposition; that absorption of septic matter took place, causing constitutional symptoms, and possibly cellulitis in the left broad ligament; that the tumefaction in the left broad ligament might also be due to hæmorrhagic effusion. I split the cervix with my instrument. The metrorrhagia, which had persisted for six weeks, and was abundant at the moment of the operation, ceased in a few days, and the pain abated.

The treatment of these cases has given rise to much discussion. It is convenient to divide the subject under two heads:

(A) The general treatment of the effects of the mechanical obstruction.

(B) The direct treatment adapted to remove the cause.

(A) Depending, in great part at least, upon a mechanical cause, any plan of action that is not adapted to remove this

is not likely to do more than mitigate the symptoms. One class of remedies will be called for to control or moderate the hæmorrhage, and to counteract the consequent anæmia. A considerable amount of success may attend the use of nitric and hydrochloric acids, cinchona, iron, Indian hemp, Chian turpentine, cinnamon, digitalis, and the other styptics and tonics in general use. I have not seen much benefit from bromide of potassium. The pain and colics will demand special remedies; opium, belladonna, Indian hemp, are often serviceable. Special treatment will also be necessary to relieve the local inflammations. Vaginitis and aggravated cases of cervicitis externa require, above all things, *rest*, in the fullest acceptation of the term—rest, functional as well as physical. To attain this end, repose in the horizontal position is important. Possibly this, aided by the application of pledgets of cotton-wool soaked in glycerine and tannin, by injections of various astringents or of plain water, by occasional cauterization with nitrate of silver, will suffice. But in more severe cases, where a large surface of vaginal mucous membrane is inflamed, spasmodic contraction of the muscular coat is apt to follow. The effect of this is very distressing. The rugæ of the vagina are preternaturally enlarged; the contractions of the muscular coat cause chafing of the opposed prominent rugæ; hence abrasions of epethelium, purulent discharge, sometimes blood, and the most intense pain. The essential condition of recovery from this state is *rest*. This I accomplish by getting the patient to wear a vaginal support, made of india rubber, of a somewhat cylindrical form, which is inflated with air after introduction. I havé not found the division of the sphincter, recommended by Dr. Marion Sims,* to be necessary. The form of vaginismus to which I am referring is, indeed, different in origin and nature from the cases described by Dr. Sims; the vaginismus here is strictly the result of inflammation. The action of the vaginal rest I employ is, first, to keep the irritable and inflamed walls of the vagina apart; the prominent rugæ, no longer chafing

[1] "On Vaginismus," 'Obstetrical Trans.,' Vol. III.

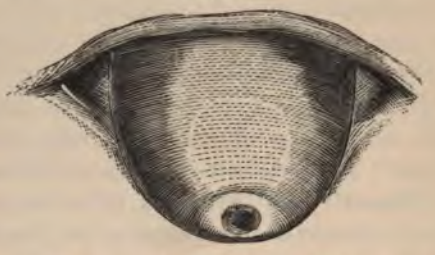
against each other, have an opportunity of getting well. Secondly, the easy mechanical support afforded to the walls of the vagina quickly subdues the morbid contractility of the muscular tissue. Very soon the inflammation and irritability subside simultaneously. By this means I have cured several very aggravated cases. In one instance—that of a lady who had been married sixteen years without being able to endure conjugal approaches, and in whom an examination was not possible without the administration of chloroform—complete relief was afforded, ending in pregnancy and the birth of a living child. The application of this principle and means of procuring local rest is much more extensive. I resort to it in cases of extreme engorgement and inflammation of the cervix, following upon labour.

It remains to consider the treatment as directed against the cause of the disorders under discussion. The importance of this treatment must be admitted when we reflect upon the severity and danger of the disorders that call for relief, and the hopelessness of giving more than partial and temporary relief by means directed simply against the consequences of a physical obstruction.

The principal means of overcoming the coarctation of the os externum uteri are dilatation and incision. It would be superfluous to enter at any length on the description of the numerous contrivances that have been devised for dilating the cervix; but it is of great moment to determine the amount of safety and efficaciousness which attend dilatation. If it were proved to be more safe and efficacious than incision, then it ought to be preferred. Evidence is conflicting. I will not venture to offer an opinion as to the relative value of the facts and arguments adduced by others. I cannot, however, estimate lightly the circumstance that men of great experience, sagacity, and resources, like Simpson and Marion Sims, have abandoned dilatation in favour of incision. They have found dilatation neither safe nor efficacious. Hæmorrhage, pyæmia, cellulitis, peritonitis, have undoubtedly followed dilatation; and it is certain that in many cases, however good the dilatation effected by bougies or

tents may appear at first, it is not of long duration. I suppose there is no dilatation by instruments more powerful than that effected by pregnancy and labour, yet even after giving passage to a full-grown child the peculiar cervix under consideration will sometimes completely resume its old vicious form. Figs. 7 and 8 are representations of cases

Fig. 5.



of this kind. The sea-tangle-tents lately come into use certainly possess advantages not before attained, and so strengthen the case for dilatation. But, admitting that dilatation can be completely attained, are all the indications, all the requirements of the case, answered? Will dilatation

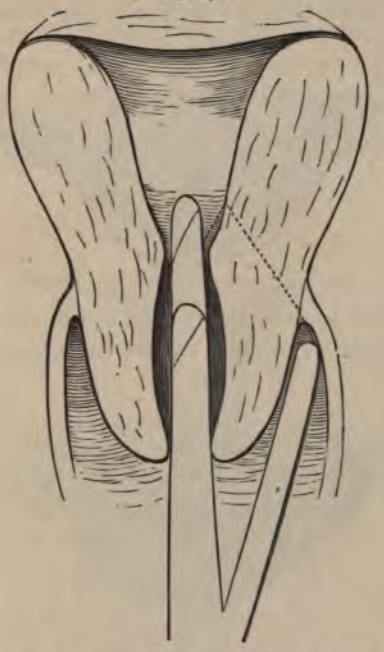
Fig. 6.

remove the congestion, the inflammation, the deviations which attend the conical cervix? Here I believe dilatation fails, and incision, or splitting the cervix, is an operation possessing a marked superiority in results.

I will briefly advert to the instruments employed. There is, first, the well-known *bistouri caché*, or metrotome of Professor Simpson. In fig. 7, is represented this instru-

ment in action. It is well adapted to answer its pur-

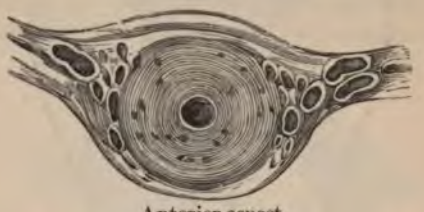
Fig. 7.



pose of dividing the cervix, but requires great care in use. After introduction into the cervix, the blade is detached from its guard in such a manner as to open at once to the full width at which it may be set by the screw in the handle. The incision it makes, if not very carefully controlled by the hand, will be liable to extend deep into the substance of the cervix at its upper part, near the junction with the body of the uterus. There is no doubt that incisions so made have actually gone through the substance of the cervix, and wounded the plexus of vessels outside. Hence severe, even dangerous hæmorrhage has been caused, and inflammation of the peri-uterine tissues. Figs. 8 and 9, taken from specimens exhibited of sections of the uterus made on a level with the os internum, show the normal size of the os internum, and the large vessels running on a line with it.

Acting, too, on the assumption that the seat of constriction is the os uteri internum, incisions have been designedly made at this part. In addition to this high and deep incision, the cervix

FIG. 8.



Anterior aspect.

has been divided so completely that the finger could feel the os uteri internum. Incisions so free in extent, and involving

FIG. 9.

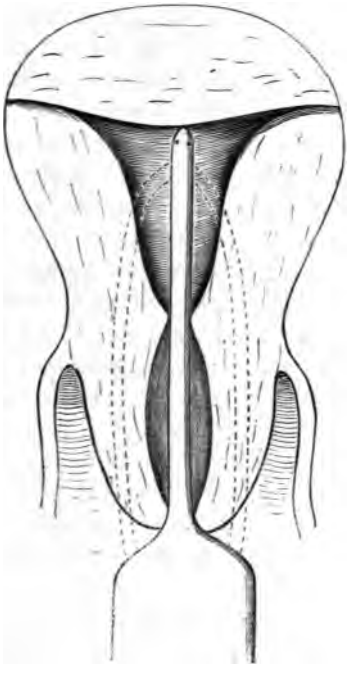
Anterior aspect.

the higher portion of the cervix—its most vascular part—may be expected to cause considerable hæmorrhage. This is a great objection—one all the more serious in that such free incision is altogether unnecessary. It will be seen that objection lies partly against the rationale of the operation, and partly against the instrument.

Another instrument has been devised on the same principle as Dr. Simpson's, but having two blades, which diverge and cut both sides of the cervix simultaneously. There is no advantage in cutting both sides at once; on the contrary, the operator having to use an instrument constructed to do its work like a machine, is deprived of the opportunity of guiding and moderating his incision. The single-blade of Dr. Simpson is less open to this objection. It may be made to work according to the judgment and skill of the operator.

Dr. Greenhalgh has contrived an ingenious modification of the double-bladed metrotome (described 'Obstetrical Transactions,' Vol. V). The blades do not diverge to the full width at once, but gradually, forming an incision of the form of an ellipsis. This is seen represented in fig. 8. The incision being narrow at the upper part avoids to some

Fig. 10.



extent the danger of cutting deeply into the substance of the cervix. The division of the projecting part of the cervix made by it does not extend to the angle of reflection of the vagina. I used this instrument for some time. Owing to the extreme fineness of the blades, the incisions made are so clean as to favour hæmorrhage; and unless great care is taken to keep the lips of the wound apart by tents, its reunion is very apt to take place. It is, moreover,

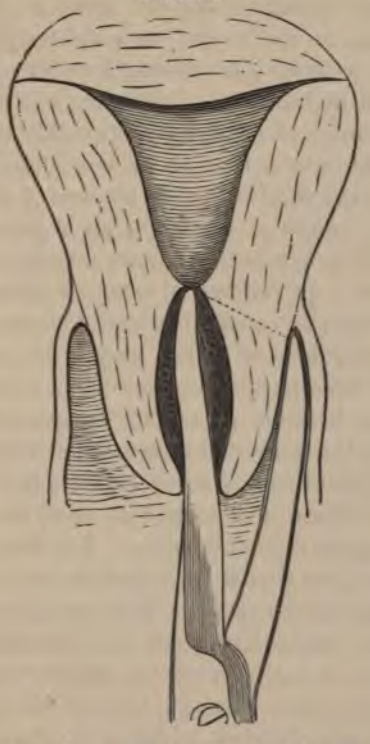
open to the objection stated against the old two-bladed metrotome, namely, that it is too much of an automatic machine; not enough of a surgical instrument.

Feeling this objection, and that an instrument should be absolutely governed by the intelligence of the operator, and not so made as to work after its own fashion, I contrived an instrument to cut like a pair of scissors, which I think is free from all the objections applying to the instruments or machines just described. One blade, strong and somewhat probe-shaped, passes through the narrow os into the cervix, whilst the other blade, slightly concave on the cutting edge, so as better to seize the rounded surface of the cervix, is applied at any point of the vaginal-portion the operator chooses. Then, the part to be divided being exactly included between the blades, is cut through. Thus we are sure of cutting as much as we want, and no more. There is this great advantage in cutting from without inwards instead of from within outwards, that *we are cutting towards safety and not towards danger;* we cannot cut deep into the substance of the cervix on a level with the os internum; the incision partakes of the crushing character. These two circumstances afford better security against severe hæmorrhage or other danger. When one side of the cervix is divided, the other is treated in like manner. The instrument is the most simple, inexpensive, and not likely to get out of order. The wound made by it is less liable to reunite by first intention. It *gapes* better than that made by the knives. With this instrument made for me by Messrs. Weiss a year ago, I have operated many times at the London Hospital and in private and consultation practices. Its action has almost always been entirely satisfactory. It produces a good os tincæ. (The instrument is represented in action, fig. 11.)

It afforded me sincere gratification to see in the 'Lancet' of the 1st of April last, a paper by Dr. Marion Sims, in which it appeared that he had for some years before adopted the same principle of proceeding as myself, and was in the habit of using a similar instrument. Our distinguished *confrère*, however, fixes the cervix by means of a vulsellum before

cutting. I have not found this to be necessary. My expe-

Fig. 11.



rience entirely corroborates that of Dr. Sims as to the safety and efficaciousness of this operation.

I will conclude with a brief *résumé* of the advantages attending division of the cervix, as I have performed it, over dilatation. I believe that dilatation is preferred by some physicians who have seen or heard of severe hæmorrhage after division by the single or double knife, on the ground that it is safer, and entails less responsibility. I doubt whether dilatation be safer than division as performed by Dr. Marion Sims and myself. I have never seen hæmorrhage at all alarming; it is usually stopped in five or ten minutes by applying pledgets of cotton-wool soaked in cold water;

and it is rare to find any secondary bleeding of moment. To guard against this, and at the same time to obviate the tendency of the wound to unite, I press a bit of oiled lint between the lips of the wound, and lightly plug the vagina with oiled lint to keep the dressing *in sitû*. I need hardly say that rest in bed for two or three days is enforced.

Any troublesome bleeding may be quickly arrested by iced water, by perchloride of iron, or by firm plugging.

So far from the inconsiderable amount of blood that need be lost being a source of danger or an objection to the operation, I am sure that in most cases moderate bleeding is a positive benefit. It relieves almost immediately, in great measure, the intense congestion and inflammation that so often arise in the conical sterile cervix in married women. I have seen a deep-purple mucous membrane covering the vaginal portion become pale and comparatively healthy-looking directly the congested tissues were divided. Moreover, the division often allows of some retraction of the lips of the new os tincæ. There is no longer the same excessive amount of projection of the vaginal portion. The free opening of the vaginal orifice of the cervical canal admits of the ready escape of the secretions of the canal. It is not uncommon for the division to give immediate issue to a considerable quantity of glairy mucus, or puriform matter, which, from its tenacity, could not easily issue through the minute opening of the cervix. These are decided advantages attending division. Dilatation can do little or nothing to relieve congestion or inflammation. Division again, by permitting the retraction and gaping of the lips of the new os, affords greater security against deviation or flexion.

As to the results of division I think I am in a position to affirm that they are, upon the whole, extremely satisfactory. The secondary congestion and inflammation of the cervix and uterus are almost certainly relieved. The congestion of the ovaries, and tendency to metrorrhagia, are commonly relieved. The pain attending menstruation also subsides. All this is a sufficient apology for the operation. And to relieve dysmenorrhœa, metrorrhagia, and to arrest the risk of

internal effusion of blood, where existence is rendered wretched, and where health is being gradually sapped, are we justified in withholding, even from unmarried women, the only hopeful prospect of relief?

In married women, the distress, as I have already shown, is liable to be much aggravated, and there is the additional motive to obviate sterility. With regard to the latter point, I may state that I have met with the greatest success in cases of young women in whom the operation has not been delayed too long after marriage. With the advance of years, and continuance of the disorders entailed by the malformation, the aptitude for pregnancy diminishes.

As to the permanency of the new os tincæ I am not able to speak with certainty. There is no doubt a tendency to contract; but I question whether the contraction ever proceeds to the extent of reducing the os to its original minuteness; nor is the risk of contraction so great as after simple dilatation. It may be necessary to repeat the operation after the lapse of some years; but I believe this will rarely happen.

In this sketch I do not assume to have exhausted the subject. My main object has been to set forth the reasons deduced from large opportunities for preferring division in the mode practised by Dr. Marion Sims and myself to dilatation of the conical cervix.

Mr. Baker Brown thanked Dr. Barnes for having brought forward this subject in so able a manner, and as he thought at a most opportune moment. The paper he considered exhaustive of the subject, and he quite agreed with Dr. Barnes that dilatation was an inefficient and only temporary remedy for dysmenorrhœa arising from stricture of the canal. He differed from the author as to the seat of stricture; he believed it to be in the cervix itself, generally accompanied by narrowing, contortions, and reflections of the canal, the results of inflammation. He thought stricture either at the internal or external os, was exceptional. Mr. Brown described his mode of operating, which was as follows. Having placed the patient in the lithotomy position, he introduced a bent speculum, and then grasping the anterior lip of the os uteri with a pair of vulsellum forceps and holding it up in the median line, he introduced Simpson's hysterotome, first having arranged the

blade so as to determine the depth of the incision to be made. He cut from within outwards completely through the os externum and neck, as far as possible, without wounding the vagina; having done this on the right side, he reversed the instrument and did the same on the left. He had no fear of hæmorrhage when the subsequent steps which he adopted were fully carried out, namely —inserting oiled lint well into the cut surfaces, and then plugging the whole vagina with lint or cotton-wool, so as to prevent any admission of air which might loosen the pledgets of lint in the wound. Mr. Brown had always found Dr. Simpson's instrument to answer exceedingly well; and had tried, but did not like the double hysterotome. He, however, thought it highly important that the operator should see what he was doing, and therefore objected to Dr. Simpson's method of operating, with the patient on the side, and using the finger as the only guide to the os uteri. Mr. Brown concluded by expressing his extreme regret that, a Fellow of this Society, of high standing, had lately condemned this operation as unsafe, and detrimental, and he did hope that a full discussion would be elicited from the fellows present, for he felt sure that the younger fellows would learn from those who had any experience on the subject that although but a few years ago the operation had been questioned by many, and considered unjustifiable, it was now recognised not only as justifiable, but as the only efficient and permanent remedy for these painful affections—dysmenorrhœa, metrorrhagia, and sterility.

Dr. Greenhalgh stated that he had listened with great attention to the president's paper, and was extremely surprised to hear that he considered the seat of stricture in cases of dysmenorrhœa to be at the external os uteri, and that the neck of the uterus was small and tapering. A large experience had convinced him (Dr. G.) that although such cases are occasionally met with, still in the great majority the seat of stricture will be found at the internal os uteri, the neck of the uterus being somewhat enlarged, and not tapering; consequently he deemed it essential that the internal as well as the external os uteri should be divided. The drawings sent round were evidently ill developed virgin uteri in which the operation is rarely or never required. After division, Dr. Greenhalgh introduced his bilateral expanding stem which keeps up steady dilatation and prevents contraction of the parts. Much had been said about hæmorrhage, but he could positively affirm that out of nearly one hundred cases of division of the os and cervix with his metrotome, in one case only was plugging had recourse to, and in this instance the patient was extremely plethoric; moreover, the uterus was much congested, and she was the subject of severe pruritus, and on the eve of a menstrual period; the operation was perfectly successful. Dr. Greenhalgh considered the great advantages of his method were

the extreme exactitude, quickness, and almost painlessness with which the incisions can be made, and that without any exposure of the patients during or after the operation. He was much astonished to hear Mr. Brown state that he only divided the external os uteri and neck, when he (Dr. G.) had seen him on several occasions freely incise the internal os uteri in the cases under discussion.

Mr. Baker Brown, in answer to Dr. Greenhalgh, said that that gentleman must be mistaken in what he had seen at the London Surgical Home. He repeated that he never in cases of dysmenorrhœa cut through the internal os. Dr. Greenhalgh was evidently confounding this operation with that for fibrous tumour, retroversion, retroflexion, &c., of the uterus, in which he (Mr. Brown) incised freely, and generally through the internal os.

Dr. Routh fully confirmed Dr. Greenhalgh's view. For his own part, he believed in by far the majority of cases the obstruction was at the *inner* and not the *outer* os; although he did not deny that in some cases of conoid cervix it was present at the external os. He agreed with Dr. Gream in believing that Dr. Sims's plan of operation would occasionally leave a deformed cervix for life; and he did not think it was necessary to cut through the entire cervix. The instrument Dr. Greenhalgh had invented obviated all danger from hæmorrhage. The same was true of his (Dr. Routh's) instrument, which he, however, preferred, because of the bend, and, therefore, more easy of application in *flexion* cases. A little bleeding was salutary. In most of these cases there was a complication of congestion, which the very incision by the subsequent hæmorrhage relieved. But there was no doubt that such incisions, however freely made, had a tendency to contract again. Hence it was necessary to keep the cut made patent by some internal uterine pessary, and for some time, it might be for months, so as to allow it to become properly lined with mucous membrane and incontractible. He knew several persons now walking about London with these. In other cases their removal had been followed by conjugal relations and pregnancy, though previously sterile for years. Of the use of sponge-tents and other modes of artificial dilatation, in these cases, he spoke disparagingly. He had seen cellular abscess and death follow their use. They should be used with the greatest caution. He also believed cases of dysmenorrhœa were more common than was generally supposed. Not only was the seat of obstruction more frequently at the *internal* os than the *external*, but, indeed, in many cases the external os was patent and abnormally so, as shown by Dr. Henry Bennet. And there were many, and by far more numerous cases of dysmenorrhœa which were in no way, due to stricture at either os. As these cases were not, however referred to by Dr. Barnes, he did not allude to them further.

Dr. SAVAGE laid before the Society an injected preparation of a virgin uterus. He said, he thought before abandoning the question in its present extremely unsettled state, the Society might deem it worth while to reconsider it on the more tangible basis of an anatomical point of view.

The preparation was one of several intended for other purposes, and had been detached from the body without previous injection; but Dr. Parson had succeeded in injecting the arteries very successfully. The chief veins were sufficiently apparent without injection.

The cavities of the cervix and uterine body had been laid open by a longitudinal incision through the anterior surface, and the cavity of the latter still further by another incision curving across from one corner to another. The incision could be readily opened and closed so as to allow of the organ being examined entire or together with the uterine and cervical cavities. The chief vessels had been isolated without material disturbance of their relations.

The length of the entire organ was 3 inches. Length of uterine and cervical cavities $2\frac{1}{2}$ inches. Length of uterine cavity 1 inch. Breadth from cornu to cornu 1 inch. Length of cervical canal $1\frac{1}{8}$th inch. Breadth at its widest part, the canal being lozenge-shaped, $\frac{5}{8}$ths inch. Length of channel of communication between cervical and uterine cavities (uterine isthmus) $\frac{3}{8}$ths inch. Breadth at its narrowest part barely $\frac{1}{4}$ inch. Thickness of walls of uterine body at their thickest parts (those most distant from the cornua and isthmus) $\frac{3}{8}$ths inch. Thickness of cervical walls $\frac{1}{4}$ inch.

The shape, size, and length of the vaginal part of the cervix varied infinitely; the cervical orifice sometimes scarcely admitting a probe, sometimes being a considerable slit.

In order to communicate with the cavity of the uterine body, the channel of the cervix gradually narrowed into the isthmus, which again as gradually widened so as to merge into the cavity of the uterine body below; the cervical channel narrowed gradually from its widest part (about its middle) to the cervical os.

Strictly speaking, there was no uterine cavity, the uterus was as if composed of an anterior and posterior half, originally split apart, afterwards brought together into close apposition, so as to unite at the edges and keep in close contact the remaining surface. Again, the trunks of the arbor vitæ of opposite sides not being opposite to each other, favoured this co-aptation.

The uterine vessels entered by its lateral edges. They consisted of several cervical branches from the uterine artery, the lowest entered where the cervix was joined by the vagina; the highest, generally a considerable vessel, by the isthmus. It was important to remember that they entered at least $\frac{1}{8}$th of an inch before beginning to subdivide.

Dr. Savage said he believed the preparation to be an excellent

specimen of a uterus which had never been impregnated. It appeared to him to warrant the following deductions:

1. Except in cases of irregular vascular distribution, which happen far from seldom, the vaginal portion of the cervix could be divided without risk of serious hæmorrhage, division beyond this would endanger the lower cervical arteries.

2. An incision laterally deeper than $\frac{1}{8}$th of an inch at any part of the canal of the cervix or isthmus would be unsafe.

3. An internal os uteri surrounded by a ring of muscle (attributed to Kölliker) as asserted by Mr. Wells, does not exist. The isthmus is surrounded by muscular fibres subjacent to the mucous membrane; but the complete identification, so to speak, of the latter with the rest of the uterus, and the extremely oblique decussations of the former could not contribute to the formation of a so-called inner os. The uterine isthmus could never form a stricture.

4. That the instruments so vaunted for the cervical dilatation of the cervix most fortunately for operator as well as patient, did little else than divide half through the vaginal portion of the cervix, and this even not efficiently. The complete division of the vaginal part of the os required the scalpel or scissors.

5. That the least bending of the isthmus, where only a bending could occur, would cause an obstruction, without the least constriction or narrowing organically, of that part of the uterine canal, such obstruction not being remediable by cutting.

Dr. Savage said experience amply confirmed these deductions. The easier introduction of a sound through the isthmus after surgical dilatation, as ordinarily performed, would be no proof that the so-called triangular incision, commencing with the division of a constricted isthmus, had been made, mere division of the vaginal portion of the cervix was constantly followed by relaxation of the isthmus, whereby could be easily introduced sounds of a size not before admissible.

He believed that obstruction at the isthmus was generally caused by uterine curvature. The canal of the cervix beyond the vaginal portion was never contracted. Obviously a very slight bending would cause obstruction, owing to the antero-posterior coaptation of the corresponding sides of the isthmus. He quite agreed with Dr. Sims, that no straight instrument would relieve an obstruction thus produced. Dr. Greenhalgh's hysterotome was the best in the automatic list of such instruments, but it was half an inch too short, could not be trusted to cut the vaginal part of the os completely through, and could not be made to pass a curvature; but suppose the uterus was straight, the passage of any such instruments through the isthmus showed that division was not required.

Dr. Sims' denunciation of mechanical dilatation of the uterine

cervix and isthmus, Dr. Savage could not comprehend; Dr. Gream, a physician of immense experience, had strongly testified to its safety. He (Dr. Savage) was under the mark in stating he had employed it at the Samaritan Hospital, and elsewhere, many hundreds of times, and in this respect would amply confirm Dr. Gream's assertions, besides being quite as safe, to say the least, it was quite as efficacious as surgical dilatation, especially when performed by the new instrumental inventions. Dr. Sims' process certainly left nothing undone; but he (Dr. Savage) had for years been in the habit of dealing with the worst of such cases as Dr. Sims had described nearly every week at the Samaritan Hospital, and never had failed in overcoming such obstructions with the sponge tent. It might fairly and properly be urged against surgical dilatation performed in any of its various ways—it was useless to do too little, very dangerous to do too much, and just enough left the uterus permanently mutilated. The operators were not the best authorities, as, unknown to them, their failures marched off to other practitioners. Dr. Gream, and indeed every man of note in this department, speak of case after case rendered worse by an indifferent operation, or exposed to all the dangers of abortion after an efficient one. Dr. Sims speaks of furious hæmorrhage occurring at the first stage, and the fatal cases are notorious and far from few.

A judicious and persevering employment of the sponge-tent would leave that justly celebrated American practitioner, Dr. Sims, scarcely anything to do, quite admitting that in a surgical point of view his process stands unrivalled. Dr. Sims having divided the cervical cavity entirely through with scissors (any scalpel with a long handle would do as well) finishes the operation by acting laterally on the isthmus with a little blade of a peculiar shape set on a long handle at an angle corresponding with that between the uterus and vagina. Reviewing what was revealed by the preparation on the table, Dr. Savage said he could scarcely, without a shudder, think of thus manœuvring with an unguarded knife within the small fraction of an inch of such vessels as the uterine vessels were.

The nature of the operation—almost momentary—which Mr. Wells said he was in the habit of practising under the bed-clothes, unless it was the same as that originally introduced by Dr. Simpson or Dr. Greenhalgh, Dr. Savage said the preparation entirely failed to elucidate. Mr. Wells did not perform these uterine operations at the Samaritan Hospital.

Did Dr. Sims even hope to obtain by his method a permanent relief of the obstruction without removing the curvature? Why cut entirely through the vaginal part of the os incurring the chance of furious hæmorrhage? Because less, as Dr. Gream had said, was followed by more contraction than ever. How many

sterilities and dysmenorrhœas were removed by the removal of the means by the hæmorrhage caused by these operations, and which the use of leeches would have effected with far greater propriety. How many of these affections were amenable to this sort of instrumentation? For cases of curvature, not one in a thousand; and what ought to be said to an operation which, when effective, left the uterine organs in a permanent state of mutilation?

Dr. Graily Hewitt thought that the two questions of the treatment of dysmenorrhœa and of sterility by means of incision of the cervix uteri had been too much mixed up together. He would say a few words respecting dysmenorrhœa. He believed that in bad cases of dysmenorrhœa the condition present was frequently retention of the fluid in the uterus, and that this retention caused the pain; and he had been at some trouble to prove this. But, on the other hand, he also thought that the condition was capable of being relieved, in most cases, without resort to mechanical treatment of the cervix uteri. The great thing was to diminish the flow of blood, and this could be regulated by general measures; but that there were a few cases in which general measures were useless he admitted. He differed from the President in reference to the most common seat of the constriction; for, although there were cases in which the os uteri was congenitally extremely small and narrow, yet in the larger number of cases of dysmenorrhœa the impediment was situated at the junction of the cervix with the body of the uterus. With regard to the best method of applying mechanical relief when such was required, he thought that cases must be treated on their own merits. Where the cervix uteri was hard and dense, the cutting operation was most indicated, the difficulty being here the greatest; but under other circumstances he preferred the use of tents as dilators. The sea-tangle net was, he considered, a perfectly safe means of dilating the cervix uteri: but, he would repeat, the cases were few requiring this treatment. As to the mode of incising the cervix or os uteri, here again the operation must be selected according to the case: no one operation could be suited to all circumstances. He would next say a few words on the subject of sterility. It was undoubted that in certain cases the cure of sterility could be effected by dilating the cervix uteri, and much had been said as to the superiority of one mode of dilatation over another. The fact was, that so long as the canal of the cervix was a little enlarged, whether by incision or by dilatation, the necessary end would be served. The great object was to secure a tolerable patency of the canal at about the menstrual period, when conception was most likely to occur. Supposing the sterility to be cured, the dysmenorrhœa, which might be associated with it would be also, in all probability, permanently relieved.

Dr. Wynn Williams,—Mr. President, I think there are none

present who will deny that in some few cases of dysmenorrhœa surgical interference is necessary, but I believe that if more attention were paid to therapeutics, the study of which it is too much the fashion of the present day to neglect, cases requiring surgical interference would be reduced almost to a minimum. This I am certain of, that in many instances the neck of the uterus has been slit up where there has been no necessity, and where the cases have in no way been benefited by such treatment. A short time ago I was consulted by a patient whose cervix uteri had been slit up on both sides, forming two large protruding lips, without any relief to her sufferings. Upon examination I found she was suffering really from gout, the uterus being much enlarged and congested by gouty inflammation. Upon the application of leeches, rest, and the injection of a weak solution of iodine, together with remedies to counteract the constitutional tendency, she got rid of her troubles, at least for the time, as she is obliged to be careful, for if she takes cold or greatly exerts herself, the gout is apt to return to its old locality, to be again removed by appropriate treatment. As to the seat of the stricture I believe it may be situated in almost any part of the uterine canal; indeed in advanced cases it is difficult to decide where the chief seat of constriction is situated, or rather where it was situated in the commencement. The sound may pass pretty readily, though not freely, the os and lower part of the cervix, to meet with obstruction higher up, the uterus in these cases being generally found to be bent upon itself at the seat of the upper constriction, with enlargement and thickening above the flexure. In many instances these cases will get well after local free bleeding by leeches, rest, the injection of a weak solution of iodine—a remedy that I have found of great efficacy in removing the congestion and thickening, the injection being made when the patient is lying on her back, and retained as long as practicable, and by appropriate constitutional remedies suited to the peculiar diathesis of the patient. In some few cases, however, it will be found necessary to have recourse to the knife; the incision should be made to commence at the seat of the upper stricture gradually enlarged to the external opening. As no surgeon would I am sure deem it necessary for stricture of the urethra in the male to slit up on either side the whole tissues of the penis, but those only in which the constriction is situated, leaving the healthy structure to be stretched by other means, so I deem it quite unnecessary and unjustifiable to cut through the whole of the tissues contained in the neck of the uterus, though it may be necessary for a time to keep the incision distended by means of tents or dilators.

Dr. Marion Sims said he was much gratified and profited by the reading of this very practical paper, and by the discussion it provoked. In speaking of the operation of incising the os and

cervix uteri, he (Dr. Sims), in one of his late papers in the 'Lancet,' had said, that this operation, if not unknown, was at least ignored and ostracised on the continent. Indeed, that it was there condemned by the highest authority; M. Nélaton being foremost amongst its opponents. That while it was performed in Edinburgh, he was surprised to find the majority of the profession here opposed to it, for where there was one to advocate it, there were scores to oppose it. That this could not long continue so; that the truth must sooner or later triumph; and this operation, which he looked upon as one of the great surgical achievements of the day, would soon be recognised as legitimate, and be so accepted by the great body of our profession. He was glad to say that the discussion this evening, and at the previous meeting, showed that he was misinformed and mistaken in regard to the estimate of this operation in London. This Society must be taken as the representative of professional opinion on any subject falling within its domain. Every speaker, so far, advocated this operation under judicious circumstances, and not a single voice had been raised in opposition to it; he, therefore, seized this opportunity of saying that he was mistaken, and that he begged leave here to make the *amende honorable* to his brethren of the profession, and to this Society as representing the profession at large. He was surprised that such acute observers as medical men generally were should differ so widely on the subject of the seat of mechanical obstruction or narrowing of the canal of the cervix, whether in cases of dysmenorrhœa, or simply those of sterility. Fortunately, in a practical point of view, this was not a matter of such great importance, as those who believed that the stricture existed at the os internum divided the cervix quite through the os externum; and hence the principles of treatment were the same in the hands of each. He agreed with the President (Dr. Barnes), and with Mr. Baker Brown, and Dr. Savage, in saying that in the great majority of cases requiring surgical interference the canal was found to be narrowed in the lower portion. He begged leave to state some facts bearing on the point—facts drawn from his note books; and first, in regard to the position of the uterus in dysmenorrhœa.

Of 129 cases of dysmenorrhœa, the position of the uterus was normal in but 20 cases. There was anteversion or flexion (for he classed the two varieties of displacement under the same head) in 81 cases; 31 of these had fibroid tumours, smaller or larger, in the anterior wall; there was retroversion (or flexion) in 28 cases; 10 of these had fibroid tumours.—Of these 129 cases the canal of the cervix was curved in 84; the os tincæ was abnormally contracted in 116, and presented a normal appearance in but 6; 4 had polypi, 8 granular engorgement.

He said he looked upon dysmenorrhœa as almost entirely a

mechanical disease. Whenever the utero-cervical canal was straight and of proper calibre, there could not, as a rule, be painful menstruation. If the canal was flexed to an undue degree, there might be a mechanical barrier to the passage of the catamenia, simply by the bending and bringing together the two opposite surfaces of the canal. Under these circumstances, we might find the obstacle at the os internum; but this would not generally be a stricture properly speaking, for the straightening of the cervix would usually, indeed we might say, would almost always, show the canal to be of normal size, by permitting the easy passage of an ordinary sound. And this could be just as readily done when the canal is flexed, provided the flexure be previously accurately ascertained by the touch, and the sound curved as accurately to suit the peculiarities of the individual case. But before attempting this we must always first ascertain by the touch the amount and direction of the flexure. Dr. Savage, and our best anatomists, tell us that the axis of the uterus, in its normal relations, stands very nearly at a right angle with that of the vagina. It may vary a little from this either backwards or forwards, according to the state of the bladder and bowel. When it turns forwards, the cervix may curve gracefully over in the shape of the arc of a circle, or it may curve more sharply at the junction of the body and cervix; or the curvature may be principally found in the intravaginal portion of the cervix. These distinctions are not so nicely marked when the uterus falls backwards; the curvature here is more frequently found at the os internum. These curvatures, often the consequence of some other affection, constitute real obstructions to a free passage of the catamenia; but they do not, as a rule, constitute a *de facto* narrowing of the canal at the os internum. He would not deny the existence of such a thing as an abnormal contraction at the os internum; but he would say that it was rare indeed to find it. It was the exception to the general rule. To show the relations of a flexed cervix and a contracted os externum to dysmenorrhœa, he said he had been in the habit of dividing his dysmenorrhœa cases into two classes, viz., painful, and excessively painful, each requiring medical aid; but the last producing great constitutional disturbances, such as nausea, vomiting, clammy sweats, &c., &c.

Of the 129 cases before alluded to, 29 belonged to the second class. Of these, 23 had flexure of the canal, 26 had the os tincæ abnormally contracted, and it was not normal in a single case. He continued—So much for the mechanical obstacles to the easy passage of the catamenia. Let us now see the anatomical peculiarities of the os and cervix uteri in the sterile condition, properly speaking.

Of 250 married women who had never conceived, 32 are excluded because of other grave complications. This leaves 218 cases to be accounted for. Of these 218,

19 had the cervix flexed.
31 „ „ and conical.
21 „ „ „ and indurated.

71 flexures.

4 had the cervix straight, conical, and indurated.
109 „ „ „ and elongated.
7 „ „ elongated (not indurated).
14 „ hypertrophied and indurated.
10 „ granular.
3 „ „ and conical.

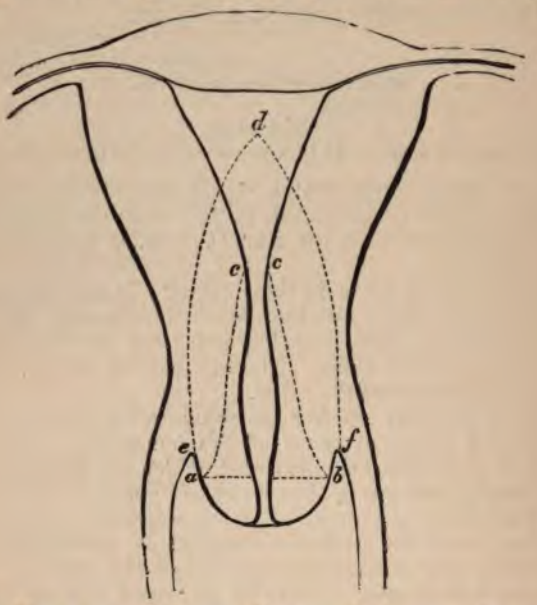
Thus we have 71 flexures, 52 of which are also of a conical form.

The above tables show that a conoid and indurated cervix existed, either singly or conjoined, in 189 cases out of the 218; 109, or half, were just such cases as Dr. Barnes describes in his admirable paper.

But what of the os tincæ in these cases? It was abnormally contracted in every case where there was induration and conoidity, viz., in 189 cases. Indeed, a conical indurated cervix is incompatible with a normal os tincæ. The existence of the one almost necessarily implies that of the other.

Now, Sir, so far every speaker has recognised a contracted cervical canal as a principal cause of dysmenorrhœa, and also of sterility, and every one has advocated, under urgent and proper circumstances, an incision of the constricted portion; but some of us locate the strictured portion at the os internum, others at the os externum; some cut from the cavity of the uterus outwards, others cut from the os tincæ towards the uterine cavity. There would, at the first glance, seem to be no reason why one method was not as good as the other, when judiciously executed. But Dr. Gream and Mr. Spencer Wells tell us that they have seen cases in which the tissue of the cervix was too largely incised, whereby the lips of the os were everted and rolled backwards. Now, I have never seen this accident follow my method of operating; but having seen one example of it after the metrotome caché method, I am satisfied that it does occasionally happen. Why then does it occur in one and not in another instance? The metrotome caché cuts deeper into the sides of the supra-vaginal portion of the cervix, dividing freely the circular muscular fibres which are naturally the antagonists of the longitudinal, and this loss of antagonism allows the longitudinal fibres to contract and therefore to retract asunder the divided ends of the cervix. This does not happen after my method, because, while I freely cut the infra-vaginal portion, I cut very superficially into the sides of the supra-vaginal portion. It therefore becomes those who use the metrotome caché to see that they set the blades of the instrument to cut not too deeply.

Let me illustrate by this diagram the two methods of operating. According to my plan, the dotted line *a b* would represent the proportion of cervical tissue divided by the scissors, while the dotted lines *a c*, *b c* would represent the extent of the incisions made by the blunt-pointed knife up towards the cavity of the



uterus. Now, upon this same diagram, let us see what would be the nature and extent of the incisions made by the metrotome caché. We will take Dr. Greenhalgh's instrument, as now made in London by Weiss, and in Paris by Charrière, as being the safest and best of its class. Lay it down upon this diagram, with the point at the fundus *d*, and the shoulder at the os tincæ, hold it firmly, so as we would in operating upon a patient, draw the blades slowly down, and the extent of their movements will be shown by the dotted lines *e d*, *f d*. The two methods differ theoretically as well as practically.

The one is based upon the idea that the obstacle to be overcome usually exists in the lower portion of the cervical canal; the other upon the belief that it is always found at the os internum. Now, by comparing the incisions made by these two methods, it will be seen that the metrotome caché divides the circular fibres of the cervix to a greater extent at the os internum, and throughout the entire cervix, than is done by my method, and as a consequence the lips of the os tincæ become inverted.

But why so? The rationale is this: the longitudinal fibres of the uterus run down from the fundus to be inserted or incorporated antero-posteriorly with the circular fibres of the cervix. These two sets of muscular fibres are antagonistic in their action physiologically. In a normal labour, the contraction of the longitudinal fibres of the body must be accompanied or followed by a relaxation of the circular fibres of the cervix, or the labour could not be finished.

In the operation of dividing the circular fibres of the cervix uteri by the metrotome caché, if the whole diameter of the cervix be cut entirely through, we must of necessity cut the whole of its circular muscular fibres, which destroys their contractility, and removes the force that bound, as it were, in a bundle the terminal extremities of the longitudinal fibres, which then take on a tonic rigidity, retracting the divided lips of the os tincæ, and producing the deformity that, we must admit, is occasionally seen to follow the metrotome caché method of operating.

Whether my explanation be correct or not does not in the least affect the fact under consideration; and the young surgeon cannot be too careful, for if he should unfortunately cut too much, there is no remedy for his mistake. It is far better to cut too little, even at the risk of being compelled to repeat the operation.

Dr. Sims then illustrated, by diagrams on the black board, the various flexures and curvatures of the cervix to be found in dysmenorrhœal cases.

The PRESIDENT was pleased to find that his paper, drawn up on a very short notice on the suggestion of others, had excited such an instructive discussion. Time did not allow of his adverting as he could wish to the observations of the several speakers. He did not dispute the proposition that there were many causes of dysmenorrhœa, requiring, of course, various modes of treatment. He had simply directed attention to one class of cases—that connected with the peculiar form of projecting vaginal portion with minute os externum, which was commonly associated with sterility. The seat of obstruction he still contended was the os externum. The isthmus at the junction of the cavities of the uterus showed that the cervix was normally so narrow that it would just admit the uterine sound: and Dr. Greenhalgh actually passed his instrument, which was even larger than the uterine sound, through the os internum. It was, therefore, quite superfluous to cut it. The specimens exhibited by Dr. Savage and himself (Dr. Barnes) showed how easily the vessels near the os internum might be divided. This danger was entirely avoided by his operation, which only split the projecting vaginal-portion. After listening to the interesting speech of Dr. Sims, he had come to the conclusion that he (the President) had underrated the frequency and importance of flexion as a cause of obstruction at the os internum.

APPENDIX TO A MEMOIR ON DYSMENORRHŒA, METRORRHAGIA, AND STERILITY, WITH A PECULIAR FORM OF THE CERVIX UTERI, IN ILLUSTRATION OF THE BEHAVIOUR OF THE CONICAL CERVIX WITH MINUTE OS UNDER LABOUR.

By Robert Barnes, M.D.

I beg leave to append to the foregoing paper an account of two cases in which pregnancy occurred, notwithstanding the existence of the peculiar form of cervix uteri described, in order to illustrate the behaviour of the cervix under the trial of labour.

Premature Labour; Conical cervix uteri; Minute os; Pelvic cellulitis; Pus spontaneously evacuated per Rectum.

(Reported by Dr. Bathurst Woodman.)

M. B—, æt. 23, a domestic servant, single, admitted into London Hospital, April 11, 1865, under the care of Dr. Fraser. She had pretty good health till about eleven months ago, when she became pregnant. After that "was low-spirited, and did not eat much." When about four months gone she had a slight fall, which "did not hurt her much." About a week afterwards she aborted (at four and a half to five months). *She flooded a good deal after this.* She began very soon after to have rigors, followed by heat and perspiration, with pain in the pelvis. The "shivering fits" came on every day or every other day at first, less frequently afterwards. About fourteen days before admission here, but six months after the abortion she was seen by Dr. Graily Hewitt. The symptoms on April 11th were as follows:—"Dysuria, pain in defæcation, and on moving her legs (especially the left); 'bearing-down' and pelvic pain; pain and tenderness in iliac and hypogastric regions, especially in left ilio-inguinal space, where there is evident 'fulness' on deep pressure. Per vaginam, there is

bulging downwards in pouch of Douglass, so as to obliterate the posterior (utero-) vaginal cul-de-sac. Per rectum, the same bulging is found to press so far backwards as to cause the walls of the rectum to be in apposition. There is evident fluctuation, though deep-seated. The uterus is fixed, or nearly so. She still has rigors and pyrexia almost every other day. Her tongue is furred, its tip and edges red, angry-looking, and partially denuded of epithelium; her appetite bad, pulse rapid and compressible, she sleeps badly, &c." She improved slightly by opiates and quinine. Dr. Barnes examined, and did not advise puncture. But about the 22nd or 23rd April a considerable discharge of pus took place per rectum (a pint or more in a vessel, and a good deal in bed), and continued for nearly a fortnight. She was a good deal relieved by this, although faint at first, and rather worried by tenesmus. There is now no apparent tumour in the situations mentioned, and the uterus is fairly moveable, although there is still a little thickening. She is much better, although still much depressed in mind, and prone to exaggerate any little feeling of uneasiness.

On examining this case I was struck with the conical form of the vaginal portion and the minuteness of the os uteri. There is no reason to doubt that an abortion had taken place at more than four months' gestation; and yet the necessary dilatation of the cervix for the passage of the embryo and membranes had so completely disappeared that some months afterwards the vaginal portion presented the characteristic features of the sterile uterus. (A sketch of the cervix taken in May was exhibited.) This and the two other cases, of which drawings were exhibited, show conclusively how little *permanent* gain is effected by mere dilatation. And if little is gained in the way of increased patency of the cervix, the proceeding fails altogether to relieve that intense congestion and even inflammation of the portio-vaginalis and cervical cavity, which so frequently arise in married life in connection with the peculiar form of cervix under consideration. Nothing short of division will relieve this engorgement.

I will now relate another case in illustration of the behaviour of the conical cervix during labour.

In 1862, I was summoned some little way out of town to aid in the delivery of a young lady who had been nearly a week in her first labour. The information I received was that the "os was agglutinated." There had been all along great constitutional disturbance. The child had probably been dead some days. When I saw her, notwithstanding the long and severe suffering she had undergone, the os would barely admit the finger, and the cervix was fully an inch and a half in length. It projected into the vagina considerably, and the lips and circumference generally were so thick that being grasped between two fingers—one inside the cervix—a hard unyielding mass an inch thick was felt. Pains still recurred, but not strongly. We had to spend three hours in overcoming the rigidity of the cervix. This was done by alternated incisions and dilatations by means of my water-dilators. The whole process was effected by art.

The delivery was accomplished after extreme difficulty by perforation and turning. The cuticle was peeling off the child. The patient, who had been long under chloroform, gave great anxiety for some time, lest she should not rally. She had made apparently a good convalescence in a fortnight, but a month later I saw her again on account of inflammation in the left broad ligament. The cervical portion did not then project much; the os was jagged and lobular. She completely recovered.

This case was an instance of the peculiar form of cervix under discussion, exaggerated by hypertrophy. I have no doubt whatever that the life of the patient was saved by the rapid dilatation of the rigid cervix effected by the free incisions and hydrostatic pressure. I have witnessed several similar cases which required similar treatment, although not one that gave rise to so much difficulty and anxiety, if I except one or two in which there was closure of the cervix from cicatricial contraction. This case explains some of the instances of what are called occlusion or agglutination of the os uteri. They are not strictly such, but

are, in reality, instances of the originally minute os which usually causes sterility.

The occurrence of pelvic cellulitis in both the cases narrated may be taken as evidence of the obstacle which the structure of the cervix opposed to dilatation, and the necessary violence attending delivery.

These cases support the statement made in the paper, that if impregnation takes place where the cervix is of the form described, it is most likely to occur in young women, and in those who have not been long married or long subject to the secondary evils apt to arise in connection with this malformation.

JULY 5th, 1865.

Dr. BARNES, President, in the Chair.

Present—36 Fellows and 4 visitors.

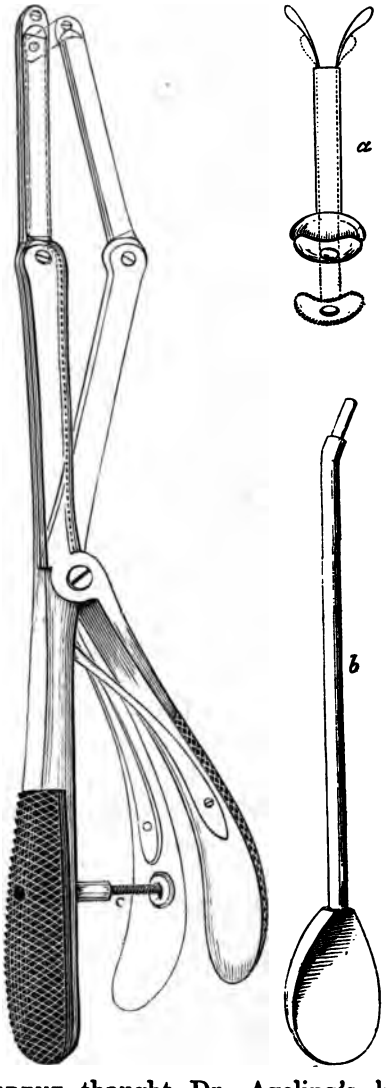
Dr. Thomas Wilson was elected a Fellow of the Society.

DR. AVELING exhibited a new hysterotome. He had previously invented and used a curved double cutting instrument, but had discarded it for the following reasons:—1st, Because two incisions must necessarily be made with it. 2nd, Because these incisions could only be made in a lateral direction. 3rd, Because the thinner and more yielding side of the uterus was divided by it to a greater extent than that which was thicker and firmer, and which consequently required division most. His present hysterotome is like Professor Simpson's, except that the hinge of the blade is at the point instead of at the centre of the instrument. In consequence of this arrangement, by simply pressing the handle, an incision is made, slight at the apex and broad at the base.

Dr. AVELING also exhibited an intra-uterine spring tent (fig. *a*) which he used after hysterotomy, and upon other occasions when metal tents were required. He had never known it cause any serious irritation, and it had one great advantage over those ordinarily used, inasmuch as it never slipped out of the uterine canal.

These instruments are all figured in the accompanying sketches, page 156, and they are represented exactly half size. In fig. *a* the dotted lines represent the springs withdrawn into the tube, and ready for introduction. Fig. *b* is a stalk, the end of which fits into *a*, and is used for the purpose of introducing the latter into the uterine cavity. There is a regulating screw represented at *c*, in the drawing of the hysterotome, upon which the handle of the instrument is pressed in cutting, as is seen in the sketch.

These instruments are made by Messrs. Hutchinson, of Duke Street, Sheffield.

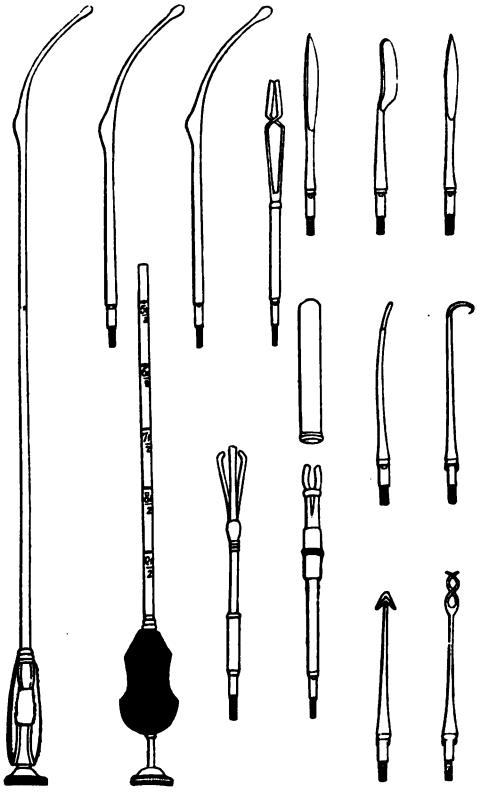


The PRESIDENT thought Dr. Aveling's hysterotome a decided improvement upon Professor Simpson's; but would

be glad to know how the instrument could be passed through a strictured os without using force?

Dr. AVELING was glad this question had been asked, as it gave him the opportunity of stating that he never operated without having previously slightly dilated the canal by means of a small tangle tent.

Messrs. WEISS and SON exhibited a very portable case of



instruments for operations on the uterus and vagina, of which the accompanying sketch is an illustration.

It contains three silver-ended sounds of various sizes; caustic, blue-stone, and lint-holders; three knives; Marion Sims's angular hook, double-pointed hook, twisted double hook and stem for introducing spring uterine tents.

The case also contains two handles which fit all the instruments.

Dr. Bathurst Woodman showed a dermoid cyst, removed after death. It was attached to the right ovary, apparently in the situation of the pons ovarium. The ovary itself was converted into an enormous polycystic tumour, larger than the gravid uterus, filled with colloid matter, in which a few cells, many nuclei, granular matter, and exudation corpuscles in great abundance were found. There were no evidences of malignancy. Ovariotomy would have been performed by Mr. Couper, but apparently from the bursting of one or two of the cysts, peritonitis set in, and killed the patient before the operation could be done. Her age was forty-seven, a married woman, living separate from her husband. Two attempts had been made at tapping some weeks before death, but the colloid matter would not run through the trocar. The dermoid cyst had been turned inside out, displaying two rudimentary teeth and hairs growing from the inside. The contents were hair and sebaceous material.

SEROUS TUMOUR IN THE OCCIPITAL REGION.

By J. Waits, L.A.C.

On the 22nd of January, 1863, I was requested to attend Mrs. M—, Poplar New Town. Upon examination, I found the os uteri well dilated, and slight hæmorrhage during each pain. I ruptured the membranes, and the head, which presented, descended very slowly. I ordered the mother to sit with her breech over two chairs, and applied a bandage round the abdomen. After a labour of twelve

hours, a female child was born with a tumour in the occipital region, much larger than the child's head. It continued to fill rapidly. I made a puncture with a grooved needle, which caused a quantity of serous fluid to escape. The child's body gradually wasted, and it expired on the 6th of May, 1863. A short time prior to death the tumour had attained the size of a two-pound loaf. By permission of the mother, I performed a post-mortem examination. I found an opening *in the os occipitus*, large enough to admit the index finger, through which the membranes of the brain protruded, with some portion of cerebral substance. The tumour was divided in the centre (*laterally*) by the membranes. The child's neck was very short; the chin resting on the sternum.

The accompanying sketch represents the proportionate size of the head and tumour, with the situation of the latter.

ON A RARE FORM OF TWIN MONSTROSITY.

By Richard Ellis, L.R.C.P. Ed., Newcastle-on-Tyne.

With Notes by D. Embleton, M.D.,

READER IN MEDICINE IN THE UNIVERSITY OF DURHAM.

At one o'clock in the morning of August 22nd, 1864, I was called to attend Mrs. T— in her second confinement; she was a good-looking and well-formed woman about thirty years of age; her husband was about the same age, and is a well-developed man, who has had a well-formed offspring by a former wife. Upon inquiry there did not appear any deformity existing previously on the male or female side of their family, nor had the mother experienced any particular mental emotion during her pregnancy which she could connect with the deformity of her children. My friend, Mr. Richard Clarke, who attended her in her first confinement, has informed me that upon that occasion she gave birth to a female having a cleft palate and imperforate anus, and that it only survived a short time. At 2.30 a.m., the os uteri being fully dilated, and feeling the head presenting, I ruptured the membranes, and the birth of the first twin took place after a few pains. It was a female, uttered a very peculiar cry, and, at first sight, had a very remarkable appearance. The cranium was rather large but was well formed; the nasal organ was a cylindrical cartilaginous body, springing from the nasal process of the frontal bone; it was about one and a half inches in length and one inch in circumference, was truncated at its extremity, and was pierced in the centre by one small canal of sufficient calibre to admit a darning needle; this organ was quite pendulous, and could be turned up towards the forehead. The thorax was well formed, being rather broader than is usually the case in a twin; the right upper extremity was well formed. The left hand was very broad, giving it a spread-out appearance, and it had a supernumerary finger. The lower extremities were much contracted and deformed, the legs being bent upon the insides of the thighs; each foot had four toes,

and presented the deformity known as *talipes varus*. This child lived about half an hour.

The second fœtus was born about twenty minutes after the first. It was a foot presentation, and at first the foot was very difficult to distinguish from a hand. The outline of the cranium was a very irregular ovoid; there was an entire absence of the eyes, eyelids, and the other appendages of the organs of vision. The mouth was a mere transverse slit. This fœtus had the same nasal organ as the other child, but it was not quite so pendulous, while it stood out more from the face; the molar and frontal bones appeared to unite directly over the usual situation of the orbits, and there were no depressions, the face presenting a firm smooth convex surface. The thorax and the trunk, in general, were rather less than in the former case. The upper extremities were remarkably long; the fingers, when the limb was extended, reaching to the knees. The lower extremities were much deformed and distorted, the feet coming straight off from the bones of the leg, like the hands, the heel being merely rudimentary; each foot had four toes, the little toes being apparently the deficient ones. The toes were very long, almost like fingers. It was impossible to determine the sex of this child, the generative organs being very imperfectly developed. This fœtus was stillborn. Both were of more than average size for twins at the full period of gestation. The placentæ were separate and were soon thrown off, and the mother has made a good recovery.

I regret very much I was unable to get possession of these specimens for dissection, and only as a great concession did I obtain permission to have them sketched. The sketch was taken, shortly after their birth, with much fidelity to nature, by Mr. R. W. C. Henderson, and was afterwards photographed by Mr. A. D. Lewis, both artists belonging to this town.

The original sketch is now in the Museum of the Neville Hall College of Medicine, Newcastle.

I am indebted to Dr. Embleton for the following interesting notes bearing upon the case.

DR. ELLIS'S CASE OF TWIN MONSTROSITY.

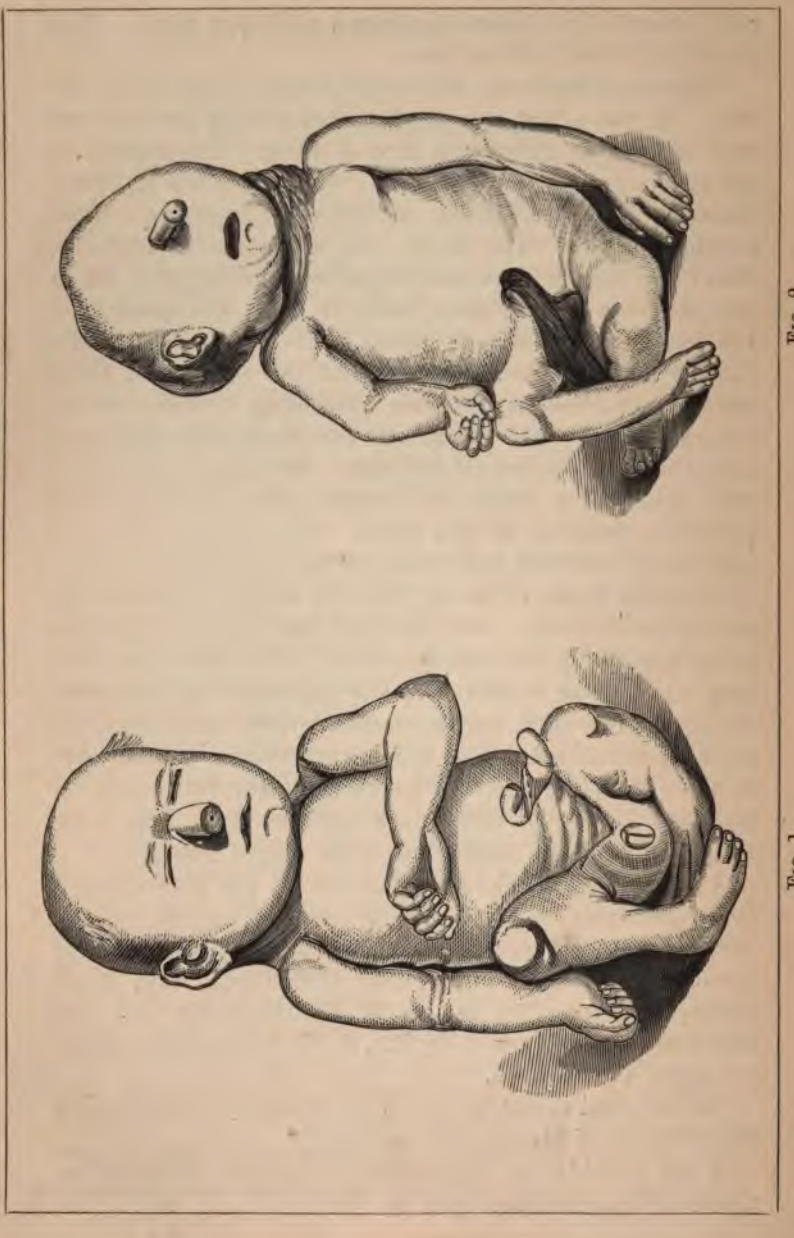


FIG. 1. FIG. 2.

"The above case of monstrosity belongs to Order I, Tribe IV, Family I, or *Cyclocéphaliens*, of J. Geoffrey St. Hilaire, but is a double example.

"The fœtus fig. 1 ranges in genus I as *Ethmocéphale*,* which is thus defined—presence of two eyes quite distinct or even somewhat separated from each other, with nasal apparatus semi-atrophied; the root of the nose exists, though much deformed, and a cylindrical eminence or trunk (*trompe*), almost entirely cutaneous, and terminated by nostrils imperfect or fused into one is presented to view.

"St. Hilaire had not himself seen an example, but quotes, from Meckel's 'Memoir on Monstrosities by Fusion,' the case of a calf, that served him as a type for the genus. This case had the same peculiarities as fœtus fig. 1, except that there were two nasal apertures in the trunk, which was two inches in length; the upper jaw was abnormally short.

"He also adduces a case of a human fœtus,† from the interspace between the eyelids of which hung down a *trompe*, which exactly resembled in size and form the penis of an infant, and was terminated by a slightly open prepuce; the upper maxillary region was somewhat deformed; the trunk generally was normal, but the hands and feet had each six distinct digits (in fœtus fig. 1 there were six digits on the left hand), but only four on each foot; both legs affected with talipes varus, and having other deformities.

"Fœtus fig. 2 belongs apparently to St. Hilaire's third genus of Cyclocéphaliens, viz., Rinocéphale.‡ This is characterised by a union or fusion of the two orbits into one, and the existence of a trunk (or *trompe*), representing the nasal apparatus. Of this genus there are many varieties which have received a good deal of attention. They depend

* 'Hist., &c., des anomalies de l'organisation chez l'homme,' &c. Par J. G. St. Hilaire, Paris, 1836, vol. ii, p. 375. See also Meckel, 'Archives,' t. i and t. vi.

† Ploucquet, "Obs. medicar pentas," dans Nov. Act., 'Nat. Cur.' t. viii, p. 26.

‡ St. Hilaire, op. cit., p. 383.

upon the modifications of the eyes and their appendages ranging from the presence of two distinct eyes in the same orbit, with distinct appendages, as lids, glands, and eyebrows, &c., to the more or less complete fusion of the eyes into one, or even to the entire absence of an eye. Now, as the abnormal modifications of the ocular appendages appear to follow exactly those of the globe of the eye itself, it may be presumed, in the absence of data derivable from dissection, and from the complete want of all external traces of ocular appendages, that this monster belongs to the latter extreme of the varieties just mentioned, some cases of which are cited by St. Hilaire.

"The narrowness of the forehead observed in this case is one of the results of this deformity.

"The feet had in this, as in fig. 1, four digits each. The length of the arms, and the fact that the feet came straight off from the legs, like the hands from the arms, would seem to indicate a somewhat Simian proclivity in this curious monster.

"St. Hilaire gives a table, from his own observations alone, of thirty-three examples of the different varieties of Rhinocéphale, as having occurred in man, in the dog, cat, rabbit, pig, and ox."

CASE OF EXTRA-UTERINE FŒTATION.

By Edgar Beckit Truman,
HOUSE SURGEON, DISPENSARY, NOTTINGHAM.

Mrs. —, æt. 32, residing in Manvers Street, Sneinton, Notts. Has had four children, the eldest being now twelve, the youngest seven. Has never had a miscarriage, or missed a menstrual period, apart from pregnancy and suckling.

On the 10th March, 1863, the menses ceased after two days' flow, the usual period being four days. Pain and

tenderness came on in the right iliac fossa, with pains also of an expulsive character; also vomiting. The urine was scanty and high-coloured, the bowels were confined, and there was general pyrexia. These symptoms increased and decreased in severity until the 6th June, when they entirely ceased. There had been no appearance of the menses since the 10th March.

On the 7th June she got up, and appeared quite well. At 3.30 p.m. she stood up on a chair to take down a picture, having to stretch a little for that purpose; she then turned deadly pale, and complained of a "queer sensation" in the bowels, adding that she thought she was going to be poorly. She lay down, and continued in a state of syncope until her death, at 5.30 p.m.

I was requested by her medical attendant to make the *post-mortem* examination, which I proceeded to do on the following day.

Sectio Cadaveris, 8th June, 1863, 4 p.m., twenty-two and a half hours after death. Body that of a well-developed woman; the breasts not enlarged; no tumour of any kind felt by vaginal and abdominal examination; the cervix uteri shortened; the os softened, its lips patulous.

Head not examined.

Abdomen.—On opening the abdominal cavity, a quantity of sanguineous serum issued, and in the cavity, extending half-way between the umbilicus and pubes centrally, and from the level of the umbilicus in each flank to the pelvis, was a mass of coagulum of blood, filling up the false and true pelvis. On removing the clot, the following was the disposition and appearance of the pelvic viscera: the bladder was empty; the uterus enlarged about two diameters in each direction; it was pushed to the left side by a mass the size of a large orange, which was placed on a slightly posterior plane to that of the uterus, and reaching to as high a level. On its upper surface was seen the opening of a vein, from which blood could be made to issue. This mass was adherent by recently formed adhesions to the pelvis by its under surface. The uterus and ovaries, with the tumour, were then removed for examination.

The tumour was opened, its walls found to be of varying thickness; at its thickest part three eighths of an inch. Attached to the whole inner surface was a placenta, but this was much thicker at the upper part than elsewhere. At this part a section showed the following parts: externally a large corpus luteum, around which was a pinkish stroma; internal to this was a thin layer of a fibrous character, and next, between this layer and the placenta was a mass of blood coagulum. Of another part of the wall of the tumour, examined by Dr. Hicks, his report is:—"I have carefully examined the specimen you sent, and find that the outer wall is formed of the wall of the Fallopian tube. The thickness is in part owing to the hypertrophied tissue proper to it, with sinuses within similar to the uterine walls; and in part the thickness is caused in a peculiar manner by deposits of hardened coagula which have been deposited amongst the villi, imbedding them. At certain parts cavities like sinuses are formed, which include bunches of villi. So like sinuses are they, that I concluded at first that your opinion was correct" (namely, that these cavities were true sinuses, in the openings of which villi had passed, as in intra-uterine fœtation); "but by examining under the microscope, I found the tissue around them was merely fibrillated blood; no muscular wall-tissue was there to be found. By then carefully tracing the true wall along the specimen, I found that it became very thin at a certain point, the remainder of the thickness being really owing to the solid clot of fibrin, in the cavities of which the bunches of villi protruded as if into a sinus. The muscular tissue of the tube was enlarged, as the uterine fibres are in ordinary pregnancy."

The placenta was similar to an intra-uterine one in its microscopical elements, namely, loops of capillaries surrounded by cells, and a thin structureless membrane; no other or maternal membrane could be made out.

Between the placenta and amnion was a spotted or granular membrane, adherent by fibrillated substance to the placenta, but merely in contact with the amnion. The am-

niotic sac was entire, and contained a fœtus of at least three months' development, being four inches and a quarter in length.

The pampiniform plexus of the right side was enlarged to three or four times its usual size. The opening of the right Fallopian tube into the uterus occupied by a soft membrane.

The uterus was enlarged about two diameters; its sinuses were enlarged; its cavity occupied by a deciduous membrane, showing a fibrous structure with numerous capillaries, the openings of follicles, and a ciliated columnar epithelium. The uterine walls were softened; the canal of the cervix uteri, as seen in its mid-horizontal section, was very small, almost obliterated; and this, not by formation of any mucous or membranous material, but by enlargement inwards of the cervical wall.

The left ovary was normal; many Graafian vesicles seen in it, and one corpus luteum, much shrunk, evidently of old date; the yellow colour quite gone. The left Fallopian tube, with its fimbriated extremity, was natural.

Mr. Roper remarked that in the two cases of tubal pregnancy which had occurred in his practice complete rupture of the cyst took place at the seventh or eighth week of pregnancy, and death rapidly followed from hæmorrhage into the peritoneal cavity. Coincident with the first symptom in each case there were symptoms of menstruation. He believed that when the ovum was in the free part of the tube (not that part which passes through the uterine wall), rupture, partial or entire, might be expected at the seventh or eighth week of pregnancy, as at this period the ovum became so large that the tube would not allow of further distension without giving way; it was therefore at this period that we might look for the first symptoms of the accident. Diagnosis of the nature of the case would be importantly confirmed by noting the time at which the first symptoms happen (whether at a catamenial period), and the actual existence of a menstrual discharge. The uterus being unoccupied, the discharge might be regarded as truly menstrual, coming from the lining membrane of the uterus; and the increased functional activity of the reproductive organs at this particular period, the additional afflux of blood, and the turgescence of the vessels concerned in nourishing the ovum,

were coincident circumstances likely to determine or hasten rupture.

The PRESIDENT called attention to the fact that previously to the rupture of the cyst—that is, previously to the shock and collapse which mark the epoch of rupture—it was usual to observe a discharge of blood per vaginam. The hæmorrhage he believed was commonly produced in this way:—The ovum growing, at about two or three months, the period when chorion is rapidly forming placenta, the rate of growth of the villi greatly exceeds that of the sac. The Fallopian tube is unfitted to harbour the ovum; it cannot keep pace with the shooting-out of villi. These become detached, and hæmorrhage results. Then, under combined distension from growing ovum and hæmorrhage, rupture takes place. It was by a perfectly analogous process, in his (Dr. Barnes's) opinion, that hæmorrhage took place in placenta prævia. Here is an *error loci*, as in tubal pregnancy: the ovum grows in the wrong place. The cervical zone is not well adapted to grow with the growth of the ovum. Hence a time arrives, about the fifth or sixth month generally, when the shooting villi get detached from the uterine wall, and hæmorrhage results. This explanation, the President observed, differed entirely from the theory generally received, which attributed the hæmorrhage to the lower segment of the uterus growing away in some manner from the ovum. The cases of tubal gestation and placenta prævia were strictly analogous in this respect. Both were examples of ectopic gestation: the ovum growing in a structure not fitted to grow in proportion with it.

Dr. PLAYFAIR asked whether Dr. Barnes thought that, either with the assistance of the symptom he had pointed out or by any other means, he considered it possible to arrive at the diagnosis of a tubular fœtation before rupture had occurred. There could be no doubt that the question of diagnosis was one of extreme importance, because if the existence of a Fallopian pregnancy could be ascertained with a tolerable degree of certainty, it might perhaps be possible to adopt some method of treatment which would save the patient from the almost certainly fatal result following rupture. Thus, for example, it might be worthy of consideration whether the operation of gastrotomy and the ligature and removal of the Fallopian tube and its contents might not be successfully resorted to. The risk from such an operation would be infinitely less than that which follows the rupture of the cyst. At present the difficulties of diagnosis are undoubtedly almost insuperable; but Dr. Barnes's interesting observations seemed to indicate a means by which they might in time be lessened or

HICKS thought the collection of the histories and
ninations of such cases very valuable,
p to guide us to the possibility of ope-

rative interference, even if the diagnosis could not be clearly made out. From what he had seen he thought in the majority of these cases there would coexist circumstances, such as adhesions, &c. which would entirely prevent our getting below the sac, so as to tie it. Even many of the cases of tubal fœtation were caused by curving of the tube by old contractions or other causes, rendering any chance of benefit hopeless.

Dr. PLAYFAIR said that he believed, as a rule, extensive adhesions would not be found in cases of tubular fœtation before rupture had taken place. After the fœtus had escaped into the cavity of the abdomen, if the patient survived the shock of the rupture, an adventitious cyst was formed round it, which was usually extensively adherent to the surrounding parts; and it would doubtless be very difficult to remove this *en masse* by gastrotomy; although Mr. Spencer Wells, in a previous discussion on the subject, had suggested the possibility of this being done. But in a tubular fœtation before rupture he (Dr. Playfair) apprehended no such difficulty would be met with.

Dr. GRAILY HEWITT observed that the diagnosis of cases of the kind now under consideration was, and he believed always would be, very difficult; and he feared that but little reliance could be placed on the circumstance adverted to by the President —viz., the occurrence of hæmorrhage as a precursor of rupture, inasmuch as it was well known that in cases of extra-uterine pregnancy hæmorrhage from the uterus was not infrequent, and that at periods some time antecedent to the rupture. With reference to the time at which rupture occurred in cases of Fallopian pregnancy, there was a very important fact to be borne in mind—viz., that, as Kussmaul had pointed out, many cases of supposed Fallopian pregnancy were really cases of bicorned uterus; and the difference in the result between such a case and one of Fallopian pregnancy with a normal uterus was necessarily very great. In the one case rupture at a comparatively early period usually occurred; whereas in the other the pregnancy might proceed normally.

Dr. RITCHIE made some remarks on the interesting question of the period at which the rupture of the sac usually occurs in tubal pregnancy. He referred to two cases which had been observed by a French accoucheur, where there was some reason to believe that the fœtus, after nine months of intra-tubal life, had been extracted by the natural maternal passages. He surmised that perhaps those cases were to be explained in the manner just referred to by Dr. Graily Hewitt: that they were perhaps instances of double uterus, where the entrance to the second horn or loculus had been mistaken for the uterine orifice of the Fallopian tube.

The PRESIDENT observed that the question started—whether gastrotomy might not be performed *before* rupture of the sac—

must greatly depend upon our means of diagnosis. He did not think that the preliminary hæmorrhage to which he had called attention, even aided by other indications, could ever raise more than a strong presumption; the evidence could hardly be great enough to justify the operation. Again, rupture commonly took place not later than three months. He had performed *post-mortem* examinations in two such cases. In both there was great difficulty in discovering and isolating the parts concerned. In the living subject the task would often be impossible.

ANTEFLEXION OF THE GRAVID UTERUS.

Dr. Graily Hewitt related the particulars of a case now under his care, in which anteflexion of the uterus, which existed before pregnancy and which had been nearly cured, was found to be present at the fourth month of pregnancy, and to such an extent as to interfere with the rising of the uterus out of the pelvic cavity into the abdomen. He was called to see her at that time, and found the os high up in the vagina, and the body of the uterus tilted forwards and pressing deeply on the bladder; the soft parts were greatly swollen, micturition exceedingly frequent, and acute pain was present. The patient was ordered to lie in bed, and in three days the uterus was liberated from the pelvis, and the symptoms became relieved. Dr. Graily Hewitt believed that anteflexion of the gravid uterus was very rare, and he had not met with any description of it. In this case the patient had been previously treated by him for anteflexion, and this gave him at once a clue to the nature of the affection.

ON THE VARIETIES OF FORM IMPARTED TO THE FŒTAL HEAD BY THE VARIOUS MODES OF BIRTH.

By Robert Barnes, M.D., President,

OBSTETRIC PHYSICIAN AND LECTURER ON MIDWIFERY AND THE DISEASES OF WOMEN AND CHILDREN, ST. THOMAS'S HOSPITAL; EXAMINER IN MIDWIFERY, ROYAL COLLEGE OF PHYSICIANS, ETC. ETC.

That the plastic property of the fœtal head is an element of great importance in the mechanism of parturition is well understood. The ring or cylinder formed by the union of the pelvic bones is almost, if not absolutely, rigid. The relation as to size between the fœtal head and the pelvic canal is so close that in almost every labour the body to be transmitted must undergo some amount of moulding in the transit. The extent and the form of the moulding will necessarily vary with the different shapes of the pelvis, the varying relations of size between the head and the pelvis, and also with the modes of birth—that is, the form imparted to the head will be influenced by the conditions under which it shall enter and pass through the pelvis. It is in order to illustrate the varieties of shape impressed upon the fœtal skull, under various conditions of birth, that I submit the present series of diagrams. To give a perfect representation of these varieties of shape, it would be necessary to take casts in plaster. But this method is not easy to pursue under the circumstances of private practice. The method I have adopted is tolerably successful in preserving the more important characters, and is very easily carried out. As soon as possible after the child is born I lay the head on one side on a sheet of paper, and trace the profile by means of a pencil. By this means we get a figure of the longitudinal section of the head. Then, to get the transverse section, the head is made to rest on the occiput, and a pencil is run round it at the greatest circumference. It

is not easy, however, to obtain perfectly trustworthy outlines by this method. There is commonly a little excess in size, owing to the difficulty in keeping the pencil accurately vertical whilst following the projections of a globular body. I have therefore generally corrected the dimensions obtained by the pencil by taking exact measurements of the diameter of the head with the calipers or *compas d'épaisseur*. The instrument I have used for this purpose was made for me by Messrs. Weiss, from the model lent me for the purpose by Dr. Martin, junior, of Berlin. Thus verified, the outlines are trustworthy. The figures obtained bring out conclusions not without interest in illustration of the mechanism of parturition. For example, the occipital elongation, producing the sugar-loaf head, resulting from protracted labour under the ordinary vertex presentation, with perhaps slight contraction of the pelvis, is familiar to every one. But the accompanying lateral and asymmetrical moulding which the head undergoes has been little, if at all, noticed. Yet it is made very manifest by the tracings now submitted. As far as my observations go, they seem to prove that, under all modes of birth, if the head is even a little delayed in its transit through the brim, it will be unequally moulded on two sides. The side which is squeezed against the promontory of the sacrum will be always somewhat flattened, whilst the side which is directed towards the symphysis pubis, suffering generally less compression, preserves more of its normal rotundity.

There is still another peculiarity in the form impressed upon the head during labour. It is one very difficult to represent by diagrams, sections, or even by photographs. It is nevertheless real, and becomes evident on observation of nature. The pelvic canal may be likened to a rifled gun; it is so constructed as to render the propulsion of the fœtal head in a direct course impossible. The head is made to revolve on its own axis during propulsion much as a conical ball revolves in its passage from a rifled gun. The difference consists mainly in the circumstance that in the case of the head this is, at starting, nearly globular, and acquires its

conicity in transition. Now, this cone, being the result of the moulding of a plastic body pursuing a helicine course, is somewhat twisted or screwed; and the lowermost or presenting apex is not formed in the median line of the head, but on one side of the sagittal suture. The deformation of the head is therefore threefold:—1. Elongation, or conification. 2. Asymetrical flattening of one side. 3. Twisting of the conified portion upon its axis.

As a general rule, it may be stated that the part of the fœtus which presents in the axis of the brim, which has to lead the way, so to speak, for the rest of the head, undergoes more or less bulging out or elongation. Thus, if the vertex present, we have the common sugar-loaf moulding; if the face or forehead present, the forehead will acquire undue, even monstrous prominence, whilst the occipital region will be flattened in. I exhibited a striking photograph of this deformity from face presentation, which is figured in Vol. V of our 'Transactions.' In the note descriptive of that photograph I called attention to the fact that the form impressed upon the head at birth is often to a considerable degree retained throughout after-life. This fact seems to offer some complex problems to the phrenologists. But, limiting attention here to its obstetric bearings, I would observe that for a long time after birth it will generally be possible by careful observation of the head, informed by such knowledge as may be gathered from the outlines now submitted, to tell what was the presentation, and how the child was delivered. This is a point not without interest in a medico-legal aspect. It is true, generally, that after birth the head quickly returns towards its natural globular form; but this return is only approximate, it is rarely complete. It depends upon two conditions—First, there is a natural resiliency or elasticity in the bones, and associated with this there is a tendency in the contents of the cranium to resume their natural position and shape. This condition acts in the dead fœtus as well as in the living. To obtain the nearest possible representation of the form of the head as it passed the pelvis, it is therefore important to take the outline as quickly as

possible after birth. But, secondly, in the case of the living child, there is another and a very active condition promoting the recovery of the natural shape of the head—that is, the influence of respiration and circulation. The effect of this is so great that it may almost be seen and felt as it goes on. The apex of the sugar-loaf rapidly becomes more truncated; the bilateral asymmetry is quickly lost to the eye, and even the frontal protuberance of facial presentation is soon remarkably levelled down, although it is occasionally still very manifest after several days.

The figures are so arranged as to exhibit in order—1st. The natural or standard form and size of the fœtal head at term. (See Figs. 1 and 2.) 2nd. The forms imparted to the head under turning in contracted pelvis. (See Figs. 3, 4, 5.) 3rd. Fig. 6 represents a head born after turning, the brim being contracted and the face having presented. 4th. A head born after craniotomy. (See Fig. 7.) This, however, is an exceptional case. 5th. The forms acquired under tedious labour, terminated by the forceps. (See Figs. 8, 9, 10, 11, 12, 13, 14.)

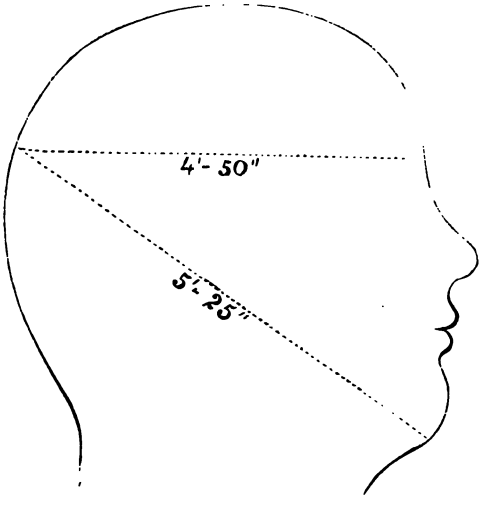
I have not given a special illustration of the modification of form impressed upon the head in head-first labour of the ordinary kind. The form so acquired is the same in character, as in lingering labour, but generally less in degree. Of heads so modified, several characteristic illustrations are figured under "Forceps Deliveries." That the form presented in these cases is really dependent upon the moulding of the head against the pelvic walls, I am well convinced. The forceps, as ordinarily used, exerts but slight compressive action; it is essentially a tractile instrument.

Case 1.—*Turning; child alive; symmetrical head.*

On the 11th March, 1865, I attended an Englishwoman whom I had on a previous labour—June, 1863—delivered by turning. On the present occasion, being at term, the right hand presented. When I saw her the hand had not descended into the vagina; the head was in the occipito-

anterior position, near the brim; the liquor amnii had

Fig. 1 A.



escaped; the cervix had expanded. I passed two fingers through the cervix and seized the right knee, which lay near, and turned easily, aided by upward pressure applied externally to the head. The cord was still pulsating; it encountered some pressure. I delivered quickly; there was no delay or compression of the head in the pelvis. Between the birth of the breech and the head scarcely two minutes elapsed. Child, a girl, well developed, was asphyxiated at first; but inspiration was soon excited, and it cried freely.

The following are the measurements and other characters of the head. The general form was rounded; it was perfectly symmetrical; there was no scalp-tumefaction or caput succedaneum. Of the transverse diameters, the smaller or inter-auricular measured 3·50″; the greatest was 3·75″. Of the antero-posterior diameters, the lesser or fronto-occipital measured 4·50″; the greatest or mento-occipital measured 5·25″. The greatest circumference measured 10·50″.

I start with this head, as representing, I believe, very

nearly the standard normal proportions and form, unaltered by the mode of birth. Such a head could not be born and

Fig. 1 B.

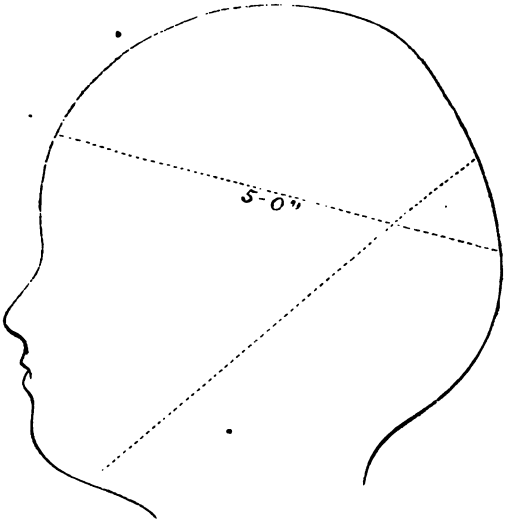
preserve the form delineated—especially the perfect symmetry of its two sides—by præcipital or head-first delivery. Under this condition, the ordinary relation between pelvis and head existing, there must be some moulding of the head during its passage through the brim. Very rapid delivery, unaided by forceps or other kind of *vis à fronte*, is very rare. But in feet-first delivery, aided by extraction, the passage of the head through the brim is a thing sometimes astonishingly easy and quick. There is no resistance, and therefore no compression and no distortion of the head. It is only under these circumstances or by Cæsarian section that we can obtain a perfect specimen of the normal fœtal head. (See Fig. 1, A and B.)

CASE 2.—*Hand presentation; cord prolapsed; turning.*

On the 17th March, 1865, I was called to a woman in labour, hand presenting. She was an Englishwoman, a pluripara; had had good times; was now in labour at term. The right hand was at the brim; the liquor amnii had escaped; the cervix was expanded; a bunch of cord, pulsating, was near the presenting hand; the head lay over the brim

to the left; the size and conformation of the pelvis were nearly normal; possible slight projection of the promontory.

Fig. 2 A.



I found the right foot near the brim; so, without passing my hand into the uterus, I brought it down. Version was effected by slight traction on the foot, and by simultaneously pushing up the head by the palm of my right hand on the abdomen. The head was thus felt to glide away upwards; the prolapsed bunch of cord was replaced and ran up. Delivery was prompt and easy, not occupying more than three to four minutes. There was a slight delay in liberating the arms. The child, a boy, was of full size and well developed. The heart still pulsated, but an attempt to breathe aborted in collapse of the chest-walls towards the spine. Sylvester's method, baths, &c., failed to restore it. The head presented a perfectly normal form. There had been no compression.

The measurements were—

Transverse (inter-auricular) . . .	3·50″
„ (greatest)	3·75″
Longitudinal (fronto-occipital) . .	5·00″
„ (mento-occipital) . .	5·50″

The similarity of the heads in the two preceding cases, in regularity of outline, dimensions, and symmetry, is striking.

Fig. 2 B.

I could bring many more illustrations to show that this is the true form of the head, unaltered by the mode of delivery. (See Fig. 2, A and B.)

Case 3.—*Contracted pelvis; turning.*

On the 28th December, 1864, I attended a patient with Mr. Ross, of the Commercial Road. I had, in conjunction with Mr. Ross delivered the same woman by craniotomy in December, 1863. Being now in her second labour, at term, and the head not entering the brim, Mr. Ross brought down a foot; but there was difficulty in getting the head to recede from the brim to complete version. When I arrived a large bunch of cord was in the vagina;

the head was over the brim, occiput to left; the left hand by the side of the head. I seized the right knee,

Fig. 3 A.

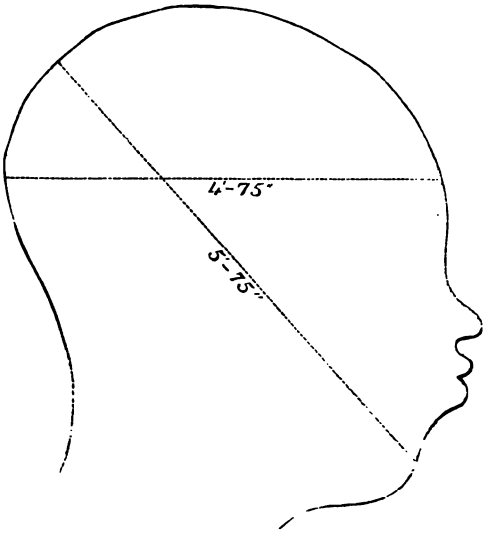
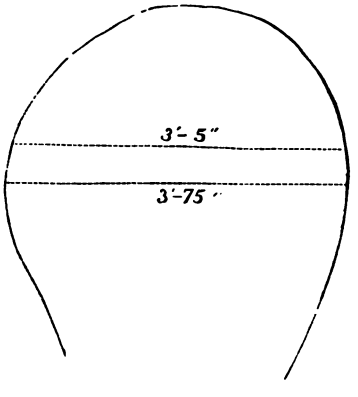


Fig. 3 B.



having pushed up the cord before me. The cord now ceased to pulsate. I found it impossible to push up the head by

external pressure, so I passed my right hand into the vagina, and pushed the head up by direct pressure with the fingers.

Fig. 3 c.

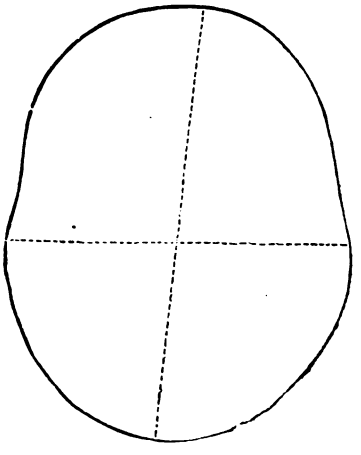
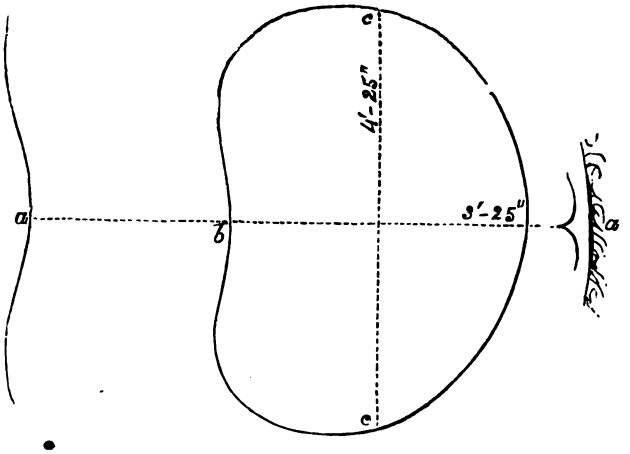


Fig. 3 D.



Rotation was then quickly effected. I liberated the arms by drawing the body over the pubis, and then over the sacrum. The head entered occiput to right. Considerable tractile force

was required. It came through very little moulded, being very firm. Child, a boy, large, well developed; mother an Englishwoman. The measurements of the mother's pelvis were—external sacro-pubic diameter 6·00″; internal or true conjugate diameter 3·25″; transverse of brim 4·25″; between the superior spinous processes of the ilia 9·75″.

The conjugate diameter of the brim was determined by the fingers, and by passing the hand into the pelvis. If estimated by subtracting three inches from the external sacro-pubic measurement, it would be three inches only.

The measurements of the child's head were—

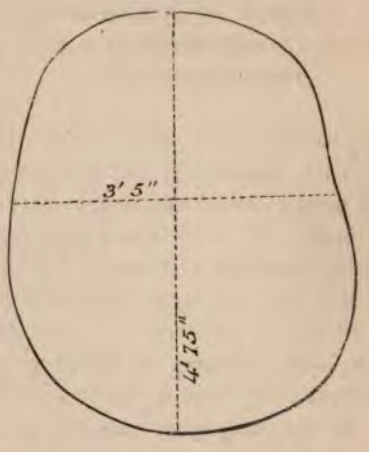
Transverse (bi-temporal)	3·50″
„ (greatest or post-auricular) .	3·75″
Longitudinal (fronto-occipital) . . .	4·75″
„ (mento-occipital) . . .	5·75″

In this case, owing to the firm ossification of the head, there was very little moulding; but on looking at section B, Fig. 3, there is seen a loss of symmetry; one side of the head is slightly flattened. If it be asked how such a head, with an inter-auricular diameter of three and a half inches, came through a pelvis whose conjugate diameter was barely three and a quarter inches, if so much; the answer is, that here, as almost invariably in cases of turning with contracted pelvis, the greatest transverse diameters of the child's head do not engage in the conjugate diameter at all. The head is nipped between the projecting promontory and symphysis pubis between the temples, where the transverse diameter rarely exceeds three inches, and where the head is compressible, and, if not sufficiently compressible to squeeze through, the temporal bone is bent in or even fractured by the projecting promontory. The occiput, including that part of the head behind the temples, finds ample room in the half of the pelvis on one side of the constricted conjugate diameter. (See Figs. 3, A, B, C, D.)

CASE 4.—*Contracted pelvis; turning; child recovered.*

On the 25th December, 1864, I attended an Englishwoman, Mrs. L—, with Mr. Blackall. She had had one child delivered dead, after difficult labour, by forceps. She had now been in her second labour some hours, the head lying on the brim in the transverse diameter, occiput to the left. The narrowness of the brim prevents the head from entering. This irregularity of form has allowed the left hand to slip down by the side of the head. Passing my

Fig. 4 A.



hand into the pelvis, I determined the conjugate diameter to be from three and a quarter to three and a half inches, and the brim more roomy to the right. I determined to turn, as the child was alive. I found the right knee on the chest near the brim; this was seized, and the head was pushed away from the brim towards the fundus uteri by external pressure. Version easy. Having liberated the arms, the head was brought into the pelvis, occiput to the right, where there was most room. It seemed quite to fill the brim. Moderate traction brought the head through.

The head was in the brim about a minute; the pulsation in the cord stopped; the child was born asphyxiated, cyanosed, with faint heart-beat. Respiration, however, was excited; the cyanosis went off, the eyes opened, and the child soon cried lustily.

The measurements of the mother were—

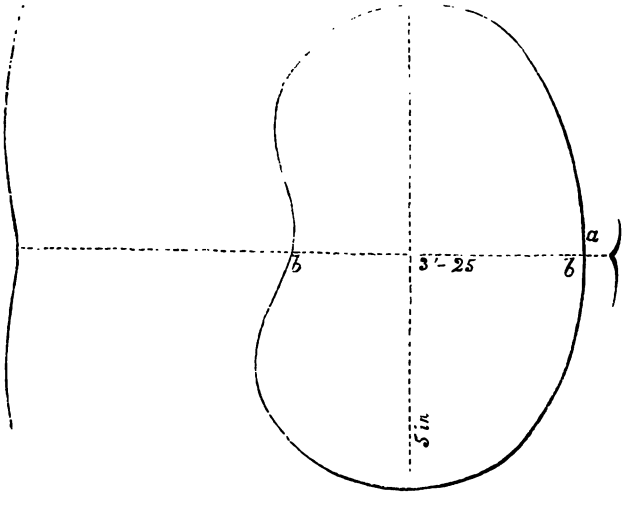
External sacro-pubic . . .	6·50″
Internal or true conjugate . .	3·25″
Transverse of brim . . .	5·00″

The measurements of the child's head were—

Bi-temporal . .	3·50″ (after crying).
Fronto-occipital .	4·75″

The size of the head being in excess of the size of the brim, some moulding necessarily took place. The head was

Fig. 4 B.



nipped in the transverse diameter between the temples. The effect was a diminution in this direction and a compensating elongation in the fronto-occipital diameter. After breathing and crying, the bi-temporal diameter increased, the fronto-occipital lessened, and the head returned towards

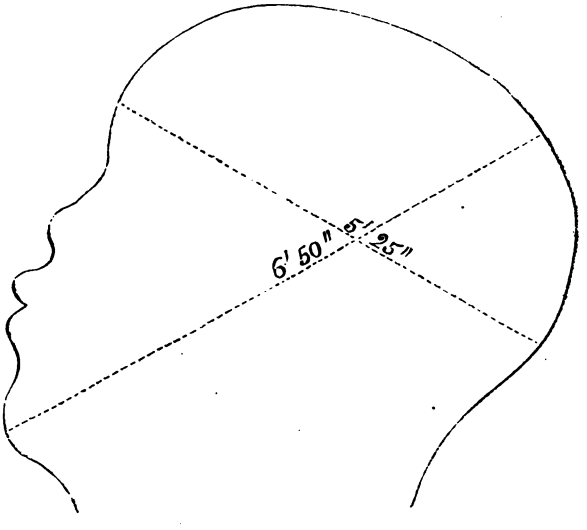
its normal shape. This recovery of form was very rapidly accomplished.

I believe delivery by the forceps in this case would not have saved the child. (See Fig. 4, A & B.)

CASE 5.—*Contracted pelvis ; podalic extraction.* (Fig. 5.)

On the 26th of April, 1864, I was called to assist a medical friend at a labour. The patient was of small frame; had been delivered of her first child by craniotomy, of her second naturally, the child alive. Is now at end of

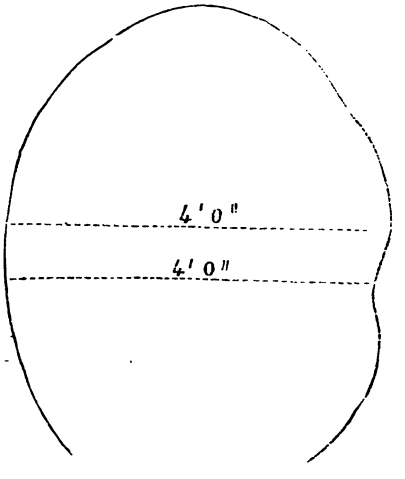
Fig. 5 A.



her third pregnancy ; labour had been active all day (25th). The head at first was at the brim, then a foot was felt. The surgeon brought this down in order to deliver by the pelvic extremity. The limbs and the trunk being extracted, the obstacle to delivering the head seemed insuperable. He endeavoured to perforate at the back of the neck ; for want of room this failed. I found a very large

child born as far as the neck; the head was mostly above the brim, lying in the transverse diameter; occiput to right, The pelvis was very shallow from coccyx to promontory; the conjugate diameter contracted. Under steady traction, directed well backwards, so as to make the head revolve round the projecting promontory as a centre, the head came through gradually, not with a jerk, as it usually does. The

Fig. 5 B.



head was very large and firm; the child dead. The mother did well.

The measurements of the child's head were—

Transverse diameter, greatest .	4·00″
Fronto-occipital	5·25″
Mento-occipital	6·50″

The contraction of the pelvis was not great. The difficulty arose from the extreme size of the head. There was a deep depression in the temporal and parietal bones of the side which lay in contact with the sacral promontory. The amount of moulding was not great. (See Figs. 5, A and B.)

CASE 6.—*Contracted pelvis ; turning.* (Fig. 6.)

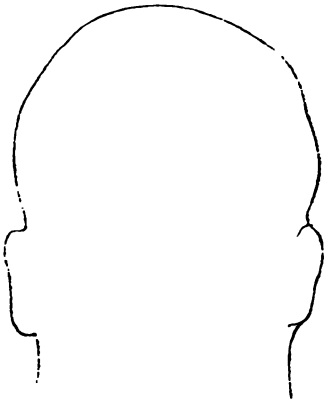
On the 14th of May, 1865, I attended a woman who had had three children, one having been delivered "by instruments;" she was an Irishwoman; the labour had lasted several hours; the face had been detected presenting three hours. I found the face at the brim, which it could not

Fig. 6 A.

enter; the forehead was to the left, the chin to the right, so that the face was nearly in the transverse diameter of the pelvis; there was great contraction of the conjugate diameter; this determined me to turn. I passed my left hand through the brim on the right; as soon as the head was shifted a very large quantity of liquor amnii was pumped out in a strong jet; the cord was felt pulsating faintly; I seized and brought down the left knee, but had to pass the hand again to push back the head, which remained near the brim. By alternately pushing on the head by the hand inside, and drawing on the leg by the hand outside, version was effected. Some time and force were required to deliver the breech; no pulsation in the cord. Owing to the narrowing

of the brim, the liberation of the arms was difficult. It was accomplished by semi-rotation of the body on its long axis, so as to throw one arm over the chest and bring the shoulders into the transverse diameter of the brim where there was most room. This manœuvre was repeated for each arm; the head came through after some little force; the child, a boy, was very large, quite dead. There was a

Fig. 6 B.



deep fossa in the left temple, formed during delivery by the pressure of the projecting promontory. The mother did well.

The measurements of the mother were—

External conjugate	. . .	6·50″
Of child's head :—Fronto-occipital	.	5·50″
Mento-occipital	.	5·75″
Post-auricular .	.	3·25″

At the seat of indentation where nipped in brim, 3·00″.

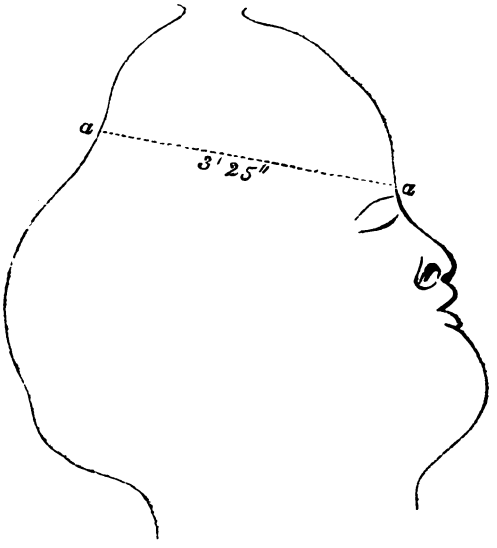
3·00″ was the extent of the conjugate diameter.

The figure (6, B) shows how the head was flattened on the sides to pass the flattened brim. To compensate for this flattening, the head was elongated in the fronto-occipital and mento-occipital diameters.

CASE 7.—*Contracted pelvis; craniotomy.*

On the 13th of December, 1864, I was called, at 7 p.m., to an Irishwoman who had been in labour many hours. She had had nine children, the last three years before; is forty years old. There is no history of particular difficulty in previous labours, nor, indeed, is it possible to get precise or trustworthy information of any kind. The external conjugate diameter measured eight inches, but, internally, the sacral promontory projected so much that the true

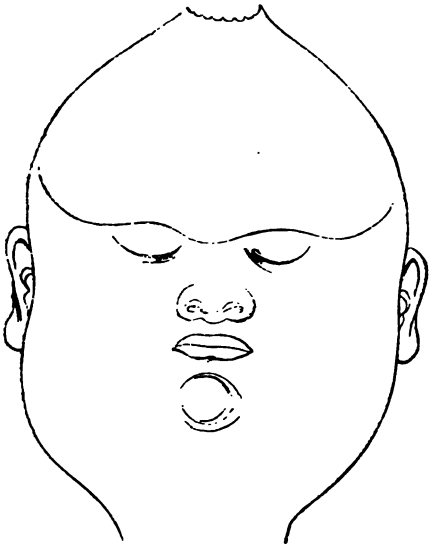
Fig. 7 A.



conjugate was barely 3·25 inches. But for the history I should have decided on perforating at once, the contraction was so great and the head so little able to enter the brim; a part of the forehead and vertex was jammed in between the promontory and pubic symphysis; the right ear was felt in the right ilium, so that it was the forehead which was jammed by the promontory. I applied the forceps, a blade

in each ilium; the locking was good, but traction had no effect. Passing my hand into the pelvis to explore the brim more accurately and determine upon the expediency of turning, I found the promontory projecting at so sharp an angle that it was actually wedged into the forehead; I therefore perforated and extracted by my craniotomy

Fig. 7 B.



forceps, steady traction during twenty minutes being necessary. The bones moulded into the sides of the brim on either side of the promontory; as soon as the skull was partially emptied the uterus contracted. Child large, boy; it had double talipes varus. Mother did well.

CASE 8.—*Arrested labour; forceps.*

On the 30th of June, 1864, I assisted Mr. Mundie, of Kingsland, at the labour of a primipara. The pains had

been strong all day. The head had partly entered the brim, when no further advance was made, although strong uterine action continued. Caput succedaneum was forming. The

Fig. 8 A.

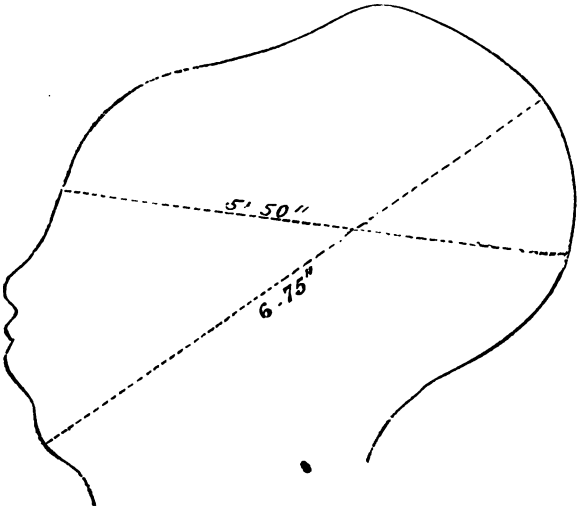
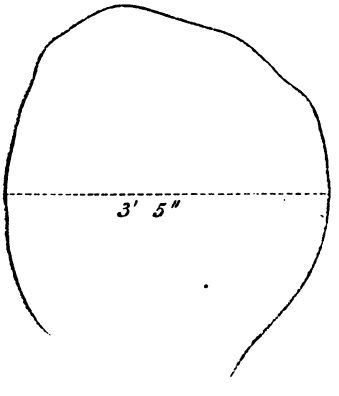


Fig. 8 B.



head seemed closely in contact with the brim all round. The conjugate diameter was slightly contracted. Gave chloro-

form, and applied long forceps. Considerable traction during thirty minutes, pains aiding, was necessary to bring the head through. Child (a girl) of ordinary size, asphyxiated in first degree, soon breathed under excitation. The caput succedaneum had largely increased during the descent of the head.

The following are the measurements of the head:

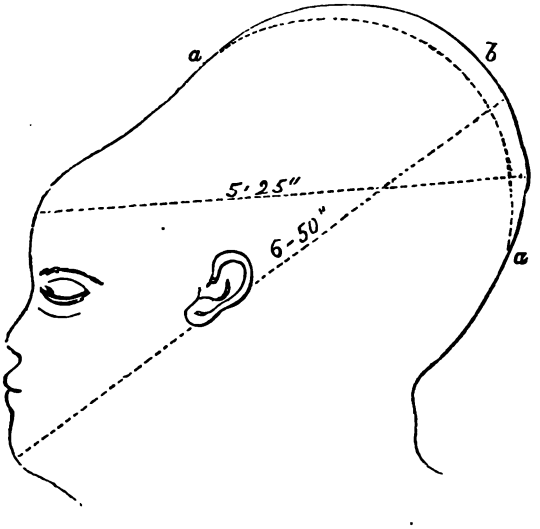
Occipito-mental diameter . .	6·75″
Occipito-frontal „ . . .	5·50″
Greatest transverse „ . . .	3·50″

(See Figs. 8, A and B.)

CASE 9.—*Lingering labour; forceps.*

On the 10th September, 1863, I was called to a woman who had had one severe labour eight years before. She had

Fig. 9.



been in strong labour all night without progress. I found the head in the first position at the brim, a large caput suc-

cedaneum over the right parietal region. The pains were still strong, but ineffectual. I applied long forceps. Extraction aided by moderate pains brought the head to the outlet in forty-five minutes. At the outlet the blades opened, slipping over the head, not being pressed into apposition by the walls of the pelvis, and, the handles being short, the leverage was not powerful enough to overcome the long levers, formed by the blades above the lock. The long two-handled French forceps would, no doubt, in such a case, keep the blades close to the head. I removed the instrument, and squeezed the head out by manual pressure applied to the sides and coccygeal region. The head was very large; the exit of the shoulders was retarded by the cord being round the neck. The cord was pulseless. Drawing on the head caused the patient to complain of dragging pain in the belly, and the cord was felt so tight that it could not be drawn down. I therefore passed ligatures round it and cut it. Child very large, meconium had recently passed. There was a doubtful beat at the heart. Restoration was not effected. The mother did well.

The following are the measurements of the head:

Occipito-mental diameter .	6·50″
Occipito-frontal ,, . .	5·25″

(See Fig. 9.)

CASE 10.—*Lingering labour; forceps.*

On the 31st of March, 1864, I was called to a pluripara who had been many hours in labour, the head partly in the cavity, without advancing. I found the head in the cavity in the first position. I applied the long forceps; traction, aided by pains, which returned as soon as the head was moved, brought the head through in five minutes. The child, a boy, large, soon cried; mother did well.

The following are the measurements of the head :

Occipito-mental diameter	. .	6·50″
Occipito-frontal „	. .	5·30″
Greatest transverse „	. .	3·50″

Fig. 10 A.

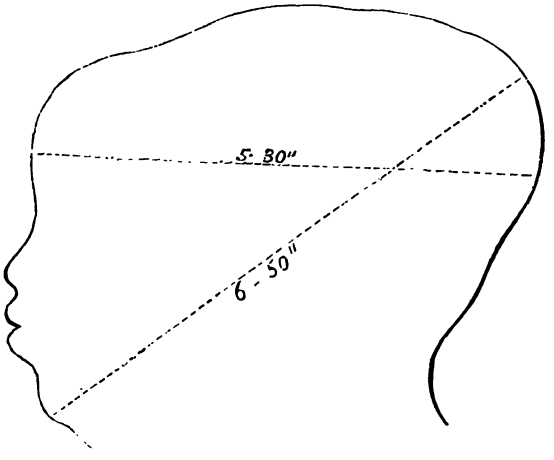
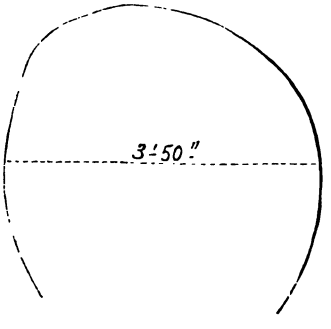


Fig. 10 B.



CASE 11.—*Lingering first labour ; forceps.*

On the 13th of January, 1865, I attended a lingering first labour with Mr. Green, of Peckham. The patient had

been many hours in labour. I found the vertex entering the pelvis, but arrested by the rigid ring of the cervix uteri, which descended low down without expanding; the head was

Fig. 11 A.

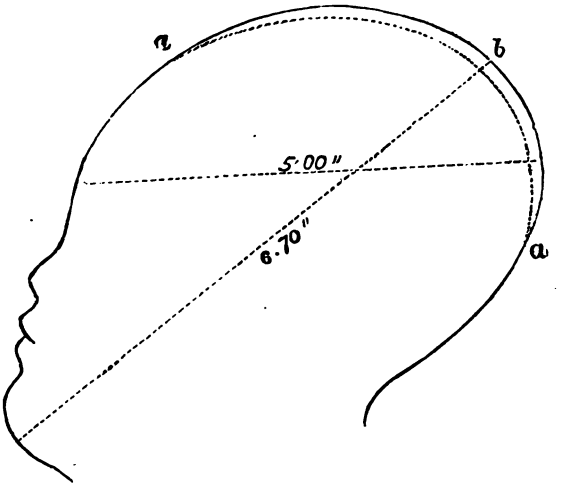
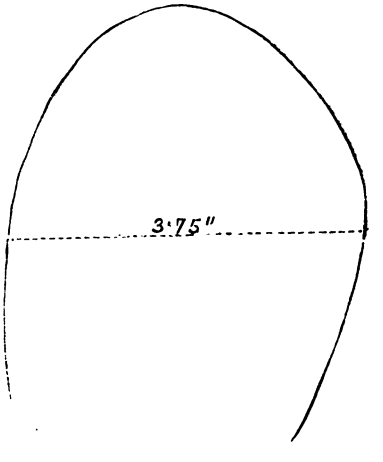


Fig. 11 B.



in the first position, elongating. I had some trouble in applying an ill-de[illegible]ble-curved forceps; the chief

difficulty consisted in passing the blades between the head and the cervix, this latter was so tightly apposed; it required considerable traction to bring the head down. After some minutes, when the ring of the cervix receded, the head quickly rotated in extension round the symphysis pubis, the delay caused by the perineal valve not being great. The child cried immediately; the mother did well.

Measurements of the head:

Occipito-mental diameter	. .	6·70″
Occipito-frontal ,,	. .	5·00″
Transverse ,,	. .	3·75″

(See Figs. 11 A and B.)

In this case the moulding was mainly required in order to pass a rigid circular os uteri; to meet this difficulty the cranium was slowly moulded into a cylindrical form. It is curious to observe how the angle formed by the intersection of the occipito-mental and occipito-frontal diameters varies in different cases. In this instance the diameters so nearly approach that the angle of intersection is very acute; in the other cases the diameters cross more nearly at right angles.

Case 12.—*Lingering labour; forceps.*

On the 10th January, 1865, I was called to a patient of the Royal Maternity Charity, a weakly woman, who had had several children. She had been in labour, at term, many hours, the head advancing slowly into the pelvis. At 5 a.m. I found the head almost wholly in the pelvis, but the pains ineffective. The occiput was directed to the left. I seized the head first with the long forceps, but it did not move. I then put on the Dublin (Beatty's) straight forceps, which more readily permitted or facilitated the rotation of the occiput forwards, and the head was quickly extracted. Child, a boy, had a very large and firm head; it lived. Mother did well.

Fig. 12 A.

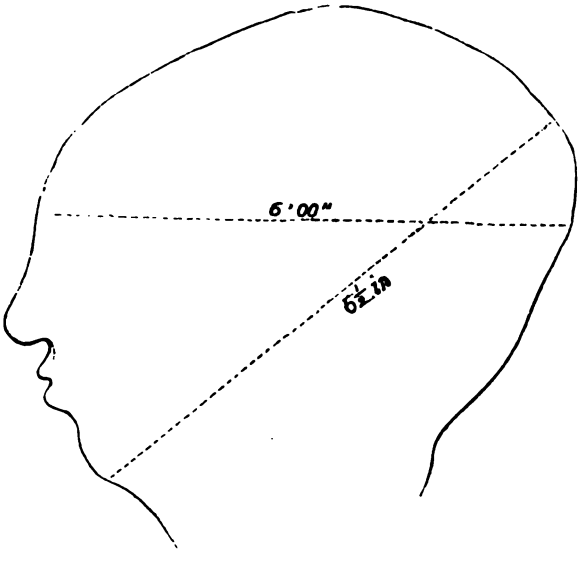
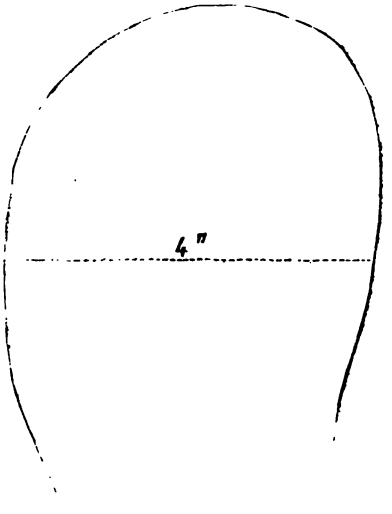


Fig. 12 B.



The following were the dimensions of the child's head:

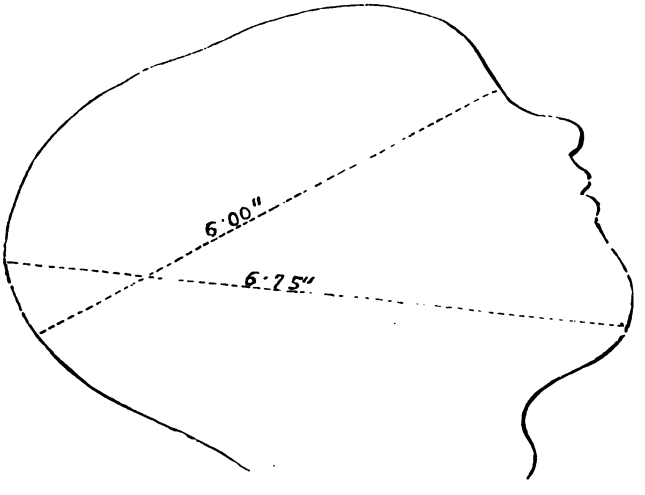
Occipito-frontal diameter	.	6·00″
Occipito-mental „	.	6·50″
Inter-auricular „	.	4·00″

(See Figs. 12 A and B.)

CASE 13.—*Lingering labour; forceps.*

On the 31st December, 1863, I was called to a woman who had been delivered of four children without difficulty

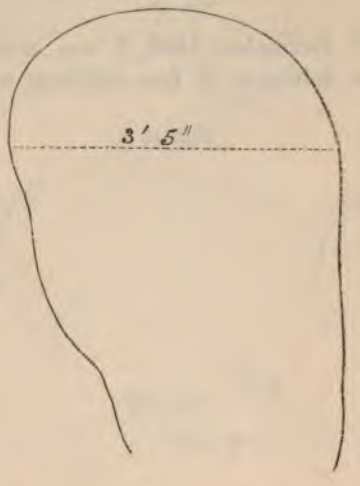
Fig. 13 A.



She had been in labour many hours, the head not descending into the pelvis. A friend had endeavoured to apply the long forceps (Dr. Oldham's), but the instrument did not lock. I found a large caput succedaneum, vertex only pointing slightly through the brim, the greatest circumference being arrested; occiput to right ilium, slightly inclined forwards. The pelvis, from coccyx to promontory, shallow. I applied the same instrument that had been already tried.

I had scarcely grasped the head when I felt a jerk, indicating that it had come through the brim; the head then traversed the pelvis rapidly, all that was done being to carry the handles well forward. As soon as the head was born it became deeply cyanosed; I therefore accelerated the passage of the shoulders. These passed with the back to the mother's right thigh. Child large and strong; it soon cried. The

Fig. 13 B.



marks of the blades were behind the right ear and the left eye. I concluded that the head had been seized obliquely, and made to rotate slightly, and that it was thus directed from a nearly transverse position into the left oblique diameter of the pelvis. The mother did well.

In my notes I find the incidental observation that the form of the blades of the instrument (Dr. Oldham's forceps) was well designed, but that the shanks were too short to seize a head at the brim; the lock had to be buried in the vulva.

The following are the measurements of the head:

Occipito-mental diameter . . . 6·75″

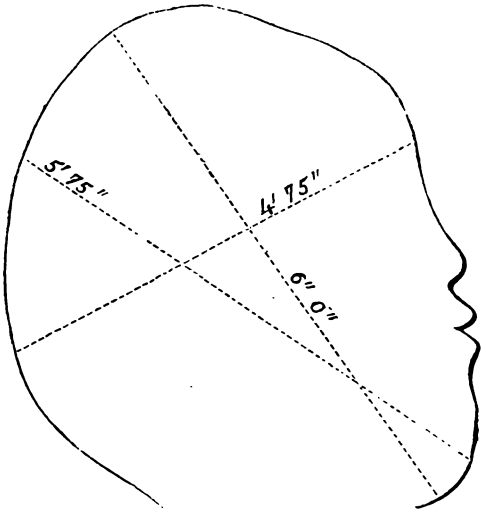
Occipito-frontal diameter	. . .	6·00″
Transverse „	. . .	3·50″

(See Figs. 13 A and B.)

CASE 14.—*Lingering labour; forceps.*

On the 19th April, 1864, I assisted a medical friend at the labour of a primipara, æt. 32. She was at term; the liquor amnii had escaped several hours; the head had partly

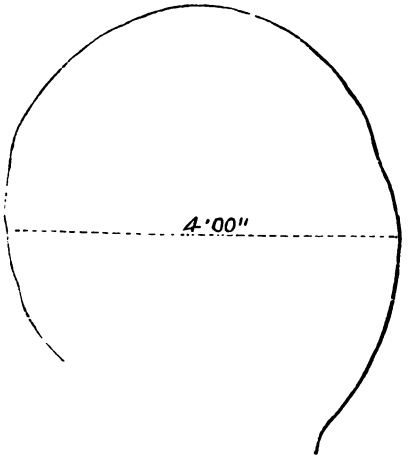
Fig. 14 A.



entered the pelvis, and then made little or no progress; pulse low; pains flagging; has had ergot; head in third position, *i. e.* occiput to right sacro-iliac synchondrosis; os uteri not perfectly dilated; perinæum rigid. Applied long forceps in the transverse direction of the pelvis. Under considerable traction, aided by uterine contraction, which returned when the forceps was applied, the head was delivered. When at outlet the forehead was nearly behind the

symphysis pubis. Cord round neck. The trunk passed with the chest to the mother's right thigh. The child at first was asphyxiated, the heart beat feebly. Immersion of the lower part of the body in warm water and Sylvester's

Fig. 14 B.



manœuvre were soon followed by respiration. The caput succedaneum was on the left side of the sagittal suture. Mother did well.

The following are the measurements of the head:

Occipito-mental diameter . . .	5·75″
Occipito-frontal „ . . .	4·75″
Longest, *i. e.* from vertex to chin .	6·00″

(See Figs. 14 A and B.)

The following deductions may be drawn from the study of the diagrams, always remembering that the number of observations is too limited to justify absolute conclusions:

1. The ordinary dimensions of a standard head at term, not deformed by labour, are—

Fronto-occipital diameter . .	4·50 to 5·00″
Occipito-mental „ . . .	5·25 to 5·50″
Greatest transverse „ (between parietal protuberances) . .	3·75 to 4·00″
Lesser transverse diameter (between the ears)	3·50″

N.B.—In comparing these measurements with those given in works on midwifery, it must be borne in mind that the measurements commonly given are taken from averages of observations made upon children after ordinary labour, in which it is more than probable some of the deformations depicted in this memoir had occurred. The outlines and measurements I have given of the standard fœtal head represent the form and size *before entry into the pelvis*—that is, they represent the fœtal factor in the problem of parturition as it exists at the commencement of labour.

2. That in protracted labour with vertex presentation, in a pelvis normal, or nearly normal, the above dimensions are altered to—

Fronto-occipital diameter . . .	5·25 to 6·00″
Occipito-mental „ . . .	6·50 to 6·75″

The greatest transverse diameter is often merged in the lesser—that is, the parietal bones are compressed so that the inter-parietal diameter becomes the same as the inter-auricular, which is fixed.

3. That in a case of tedious labour, with the head in the third position of Naegelè, the elongation was greatest in the bregmato-mental diameter—that is, the elongation more nearly approached the vertical diameter of the head than the longitudinal diameter.

4. That elongation of the head is due sometimes entirely, and often greatly, to the pressure the head experiences in passing a rigid, imperfectly dilated cervix uteri. Hence the conical elongation is most marked in primiparæ; hence also one reason why the forceps is so much more frequently called for in first labours.

5. That in turning, in contracted pelvis, from projecting

promontory, the transverse flattening of the head is much exaggerated; that in extreme cases, the moulding capacity of the cranial bones being exhausted, space is gained by indentation or even fracture of the bone in contact with the promontory; that the lateral or transverse compression is compensated by slight mento-occipital elongation—that is, this diameter increases a quarter or half an inch, and also by fronto-occipital elongation.

As illustrating the mechanism of delivery by turning, in contraction of the conjugate diameter of the brim, it is interesting to observe (as Simpson, indeed, has noticed) that the part nipped between the promontory and pubis is not the greatest transverse diameter of the head, but *a part anterior to that of greatest width,* namely, between the temples. The greatest width and the occiput always find room to pass in one side of the pelvis, where it expands behind the projecting promontory. The mechanism of such a labour is this:—When the head is brought down base foremost to the brim it at once adjusts itself to the figure of the rigid ring to be traversed; the head descends until the temples are caught between the opposing points of sacrum and pubis; then, traction being continued, the head revolves a little way upon the transverse axis at the point pinched; the occiput is consequently drawn down upon one side of the brim; next, the promontory forming a very prominent, even angular projection, seizes the head more firmly than the smooth concave symphysis, and therefore forms the fixed point around which the head must revolve in order to escape. In the mechanism of such a labour as we are considering the promontory is the counterpart of the pubis at the end of natural labour. The head has first to describe a large part of a circle around the promontory as a centre, the part in contact with the promontory being fixed—not gliding past it—and the side of the head in contact with the pubis taking a large sweep, until the head has escaped from the strait into the pelvic cavity. Now the labour becomes natural, and the pubis is the centre around which the head revolves, describing the curve of Carus in its exit.

From this view it follows that, to extricate the head from the straitened brim, the traction must be made in the axis of the brim, or rather backwards in a curved line, taking the promontory as a centre. When this, the first curve, has been made, the traction must be directed in the axis of the outlet or in the curve of Carus. It is from want of attention to this law that I have known several practitioners fail to extract the head, although it came easily when the law was afterwards observed.

DESCRIPTION OF THE FIGURES.

FIGURE I.—A and B. Pluripara; hand-presentation; pelvis normal; delivered by turning; no delay; no compression; giving the standard size and form of head unaltered by mode of birth.

The greatest circumference of the head was 10·50 inches.

„ II.—A and B. Pluripara; hand-presentation; delivery by turning; no compression of head; no caput succedaneum; boy; full term; heart, beating could not be restored; standard form and size of head; perfect symmetry.

„ III.—A, B C, and D. Turning in contracted pelvis; ossification firm; very little moulding; considerable traction force to bring head through.

A. Longitudinal section of head.
B. Transverse section of head.
C. Horizontal „
D. Outline of brim of pelvis.

„ IV.—A. Horizontal section of head.
„ B. Outline of pelvic brim.

The right half of the brim, the larger, received the child's occiput; girl; delivered by turning; born asphyxiated; recovered.

Circumference of head 14·00 inches.
Circumference of brim 14·50 „

„ V.—A. Longitudinal section of head.
„ B. Transverse „

Large female child; delivered by turning; dead.

Fig. B shows deep indentation of left parietal and temporal bones caused by projecting promontory.

FIGURE VI.—A. Longitudinal section of head.
" B. Transverse "

Irish child, male; contracted brim; delivered by turning; dead.

Fig. A. Right eye and lip swollen from face-presentation; * indentation caused by projecting promontory; the transverse diameter from deepest point of this pit to the opposite side of the head was 3 inches.

" B, shows general flattening of head by approximation of the sides.

The larger or occipital half of the head passed through the right side of the brim, so that the largest transverse diameter (3·25″) did not engage in the conjugate diameter.

VII.—Contracted pelvis; craniotomy.

B.—*a*—*b*. Line showing seat of constriction between promontory and pubis.

c. Seat of perforation.

" VIII.—First labour; first position; arrest in brim; slight contraction; long forceps; child alive; girl.

A. Occipital elongation; caput succedaneum.

B. Lateral distortion of head and narrowing of transverse diameter to make the elongation in the mento-occipital diameter.

" IX.—Head arrested in first position at brim; long forceps; child very large; strangulated by cord round neck.

" X.—Male child; first position; retarded in pelvis; long forceps.

A. Mento-occipital elongation; bregmato-occipital compression to make the conical elongation.

B. Lateral distortion and slight compression to make the mento-occipital elongation.

" XI.—Tedious labour in primipara; slight pelvic contraction; great rigidity of cervix uteri the chief obstacle; curved forceps, requiring great traction; girl alive.

A. Great occipito-mental elongation; caput succedaneum.

B. Transverse section, showing compression and lateral distortion.

" XII.—Labour lingering; pelvis normal; long forceps.

A. Occipito-mental and occipito-frontal elongation.

B. Lateral distortion.

" XIII.—Irish child; tedious labour from left oblique presentation; head delayed at brim; long forceps; child alive.

A. Mento-occipital elongation.

B. Transverse section, showing lateral compression and distortion to make the occipito-mental elongation.

FIGURE XIV.—Difficult first labour; third position; head arrested in cavity of pelvis; forceps; child alive; caput succedaneum on the left of the sagittal suture.

A. Mento-bregmatic elongation greater than mento-occipital.

B. Lateral distortion.

OCTOBER 4th, 1865.

ROBERT BARNES, President, M.D., in the Chair.

Present—37 Fellows, and 13 visitors.

The following gentlemen were elected Fellows of the Society:—James Fowler, Esq., Wakefield; Dr. Robert Harvey, Indian Army, Bengal Presidency.

Henry Woodruffe Bailey, Esq., Thetford, Norfolk, was elected an Honorary Fellow.

Dr. BARNES exhibited the uterus of a woman who had died after simple tapping, in St. Thomas's. There was great ascites and advanced cirrhosis of the liver, with old and recent peritonitis. One Fallopian tube had become occluded by inflammation, and then distended in a cystic form by the accumulation of fluid in it.

He also exhibited an instrument, made for him by Messrs. Weiss, for the purpose of facilitating the introduction of the perforated laminaria-tent into the cervix uteri. The tent was mounted on a wire stem connected with a flexible tube like a catheter. The tent, thus supported, was passed into the uterus through the os internum, if necessary, as easily as the uterine sound, and, being there, by pushing up the flexible tube, the wire was withdrawn from the tent, leaving this *in situ*. The instrument worked perfectly, and had been approved by other practitioners who had used it.

Dr. Barnes laid before the Society the original cephalotribe of Baudelocque. For this very interesting present to their Museum he said the Society was indebted to the thoughtful mediation of their Honorary President, Sir Charles Locock. Madame Petitjean, of Paris, who inherited the instrument from Baudelocque, wished it to be preserved by the Obstetrical Society of London. The President felt sure the Fellows would show their appreciation of the esteem manifested towards them by passing a cordial vote of thanks to Sir Charles Locock and Madame Petitjean.

Dr. Priestley exhibited a variety of medicated pessaries and suppositories which he had been requested by the manufacturers, Messrs. Duncan and Flockhart, of Edinburgh, to show to the Society. They had been made at the suggestion of Professor Simpson, with the view of administering a diversity of drugs by the vagina and rectum.

The vaginal pessaries were so far new that they were of a convenient Minié-bullet form instead of round, and all were readily dissolved at the temperature of the body, although perfectly hard before introduction.

Mr. I. B. Brown, junior, exhibited a new preparation of chloroform for administration during labour.

It was prepared by mixing one part of rectified spirits of wine (in which the essence of eau de Cologne had been previously distilled) with two parts of chloroform. The result was a clear liquid of specific gravity 1·152, which allays all pain during labour, but does not produce total insensibility. To this mixture, made in the first instance by Messrs. Anderson, of Berkeley Place and Duke Street, Mr. Brown had given the name of *chlorætherine*. The mode of administration was simple, and did not involve any particular attention from the more immediate duties of the accoucheur.

Mr. Brown concluded by relating two cases (out of several) in which he had administered the chlorætherine. The first was a fifth labour, requiring the use of forceps, and where chloroform had been given in all previous confine-

ments; the second, a case after ovariotomy, in which labour was retarded by severe pain in the region of the wound, and which was entirely allayed and labour expedited by administration of the anæsthetic.

CASE OF TWIN PREGNANCY.

By John Way, M.D.

(Communicated by G. C. P. Murray, M.D.)

Mrs. M—, a healthy primipara, living in Pimlico, æt. 21 years. Married December 24th, 1864. Catamenia last appeared on the fourth day after marriage. In the presumed eighth week of pregnancy Mrs. M— sustained a shock from being sprung at, and greatly terrified, by a large dog. Quickening took place in the nineteenth week, and delivery of twins on the 267th day after the commencement of the last menstrual period, viz., on September 24th, 1865.

One child had apparently arrived at full term, and presented no defect of development; in its case the presentation was natural, as was the progress and termination of labour. The blighted fœtus submitted to the consideration of the Society, and which would appear to have perished at about the fourth month of intra-uterine life, had been felt presenting in the first stage of labour between the bag of membranes of the living child and the posterior wall of the uterus; it was easily movable upwards, and ceased to present itself as the head of the mature child descended. It was expelled with the placenta, to which it was found to be attached by a slender cord. The portion into which the cord is inserted is dense, hard to the touch, yellowish in colour, and under the microscope presents the aspect of

advanced fatty degeneration. The larger portion of the placenta, and with which the cord of the mature child was connected, presents no abnormal appearance.

CASE OF VASCULAR (ERECTILE) TUMOUR IN THE SHEATH OF THE FUNIS IN A NEW-BORN INFANT.

By Fred. Lawton, Esq., of Chiddingfold, Surrey.

(Communicated by Dr. J. Braxton Hicks.)

The following case occurred in the practice of Mr. Fred. Lawton, of Chiddingfold, Surrey.

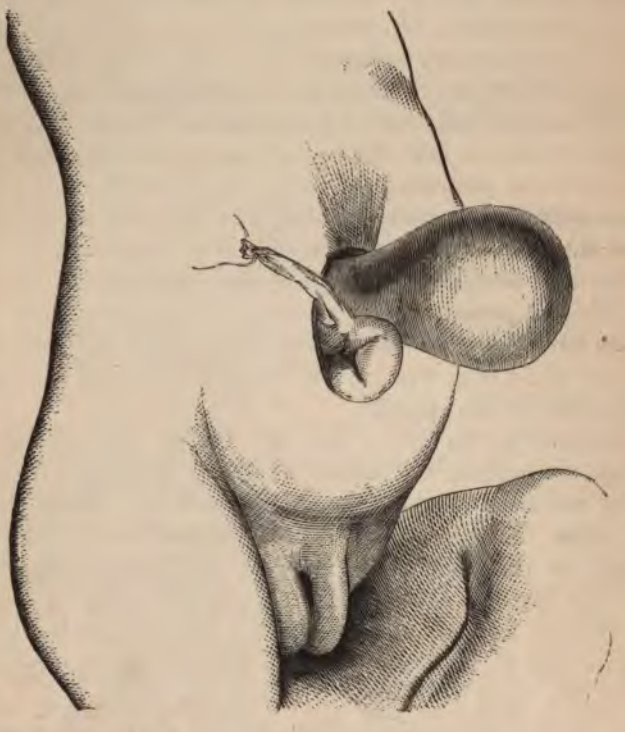
Mr. Lawton was called to the delivery of a fine male child, and when he proceeded to tie the funis he found a tumour the size and shape of a medium jargonelle pear, with its neck communicating with the cavity of the abdomen through the umbilical opening, and strongly adherent to the cord, the coverings being common to both. Mr. Lawton divided the cord above the tumour in the usual way. On examination the growth felt tough, rather fleshy, and somewhat like a placenta might feel before degeneration commences; it did not feel at all like intestine, although when the child cried both it and the investing membranes, together with the tegumentary portion of the umbilicus, enlarged very much, the tumour from being engorged with blood, and the membranes from protrusion of intestine. Pressure reduced the one and somewhat decreased the size of the other.

Reducing the hernia, pressure was applied by means of a pad and bandage, and it was resolved to wait and see what might be the termination of the case if left to nature, thinking it might dry up and slough with the cord. After a day or two affairs presented nearly the same appearance as at first,

and Mr. Lawton determined to explore a little. He did so by carefully dissecting (over the fundus of the tumour) the outer covering, when a clear yellow serum exuded; he then made a small opening into the second covering, and blood of a dark colour flowed pretty freely; a pad and bandage was immediately applied, and the case was allowed to take its course for two days more. On entering the room on the third day (after the exploratory operation) the smell of the decomposing membranes was strong, and the integument around the umbilicus much inflamed; the opening (umbilical) was large enough to receive four fingers, and was more or less oval; at the lower end protruded a knuckle of gut, at the upper end a non-pulsating pyriform tumour, and the cord at the right hand side, and between the knuckle of gut and tumour; the membranes were gangrenous, and the fundus of the tumour was bare; it presented a dark colour; to the touch it felt firm unless strongly compressed, when it somewhat diminished in size and was a little flaccid; the crying of the child gave now no impetus to the tumour.

Assisted by his friend Mr. H. Marsh, he resolved to return the protruded intestine, and, after applying a ligature round the neck of the tumour, to excise it. After giving the child chloroform Mr. Marsh applied his finger and thumb to the neck of the growth and fully compressed it. Mr. Lawton made a slight incision into the fundus of the tumour, and on carefully relaxing the pressure the blood was inclined to flow very freely; a ligature was then applied round the neck of the growth, but, the membranes being gangrenous, it cut through them, and the abdominal muscles becoming rigid at the same time, from eight to ten inches of gut were protruded. Mr. Lawton excised the tumour above the ligature, re-tied the cord as low down as possible, and, after careful and patient manipulation, the protruded intestine was returned; then while Mr. Lawton kept the stretched integument intact Mr. Marsh passed through four common needles, in place of harelip pins; a pad and bandage were applied in the usual way. The child's bowels were not moved for three days after the operation, when

they acted freely. The mother not having milk for the child, a neighbour was called in to suckle it three times a day, and it was ordered very small doses of brandy. The little patient had no bad symptoms, and is now quite well.



The accompanying drawing will explain the position of the tumour.

MICROSCOPICAL EXAMINATION OF THE TUMOUR.

By Dr. J. Braxton Hicks.

The whole mass was freely penetrated by large blood-vessels, of the ramifications of which it was principally composed, coupled with areolar tissue, in the network of which were nucleated cells of round or oval form, generally in groups of four or five. There was in some parts, however, an excess of the connective-tissue elements, so as to form solid portions.

ABSTRACT OF A PAPER

ON PROCIDENTIA UTERI,

READ BY

J. Marion Sims, M.D.,

HON. FELLOW OF THE OBSTETRICAL SOCIETY.

The replacement of a chronic inversion was formerly thought to be impossible. Now, however, it is proven to be not only possible, but quite practicable.

I have had but two cases of chronic inversion. In one the uterus was removed by the écraseur, in the other it was replaced in five minutes under the influence of ether. One had existed for nine months, the other for twelve. One was at the Woman's Hospital, the other in private practice.

In the first case the patient, Mrs. R—, was cautiously etherized. The hand was then passed into the vagina, the uterus grasped, and steady efforts made to replace the organ. These efforts were continued for nearly four hours. The uterus was partially replaced; that is, it was reinverted to

such a degree as to place the fundus up within the os uteri, but it could not be passed further. The diagram (fig. 1) would represent what I mean.

Fig. 1.

About eighteen days after this (July 12th) the patient was placed again under the influence of ether, and another effort made to replace the uterus; but after an hour's time we were obliged to desist, and it was then thought that the entire ablation of the organ would be a safer operation than to make another effort to reinvert it. A few days afterwards menstruation came on, was exceedingly profuse, and the fundus was again forced somewhat into the vagina in spite of the tampon. The uterus was then pulled down into the vagina, and a strong ligature was passed round the cervix, and firmly tightened by a small screw écraseur, with the intention of ultimately removing the organ. The ligature controlled at once the hæmorrhage and wholly arrested the circulation of the fundus, as manifested by its sudden deep purple colour. But the constitutional disturbance was so intense and alarming that we were compelled to remove the ligature apparatus at the end of two hours. The great pain, excessive nausea, rapid pulse, clammy skin, jactitation and pinched features, were too distressing to be witnessed, much less endured, and so the ligature was removed, and opiates were freely given till she was entirely relieved. A general course of invigorating treatment was followed. Menstruation in August lasted eleven days, but the flow was not very great at any time.

After the September menstrual period one more effort was made to reinvert the uterus; but we could effect no more than is shown in the diagram (fig. 1).

After this she and her husband begged to have the organ removed, as we promised to do it with the écraseur without pain.

Accordingly, on the 1st of November she was chloroformed, and the chain of the écraseur was passed round the cervix, near the os, and tightened. When the operation was half finished a link parted. Another chain was applied, and with this the organ was cut through; but the broad ligament on the right side was fortunately not wholly severed. As the chain was felt to pass suddenly through the uterine tissue I was about to remove it and the severed tumour together, when all at once the most fearful hæmorrhage I ever encountered took place, and in an instant the vagina was full of arterial blood. If the bleeding had been from the blood-vessels of that portion of the broad ligament already severed and retracted within the peritoneal cavity it would have been beyond reach, and, of course, our patient would have died before she could have recovered from the effects of the chloroform. Fortunately, the bleeding was from that part of the broad ligament still adherent to the severed uterus. Quickly drawing it forward, I passed the fore and middle fingers through the cervix uteri into the abdominal cavity, and with them compressed the remains of the ligament against the edge of the cervical opening, which promptly arrested the hæmorrhage. The blood was then sponged out of the vagina, and the undivided portion of the broad ligament with the artery was tied, after which a few sponge-probangs were passed into the peritoneal cavity, and the blood that had found its way there was carefully removed. It must not be forgotten that the patient was in the usual lateral semiprone position. The divided edges of the cervix were united by five or six interrupted silver sutures. The one on the extreme right was made to transfix the ligated portion of the broad ligament, which had been drawn through into the vagina. The edges of the cervix united by the first intention. The opening through the cervix, before it was closed by the sutures, would easily have admitted the passage of three fingers at a time into the peritoneal cavity. This was rather a fortunate thing under the circumstances, as it afforded great facility for sponging out the blood from the peritoneal cavity.

I have occasionally heard from Mrs. R— since the operation, and she remained in good health.

The other case was that of a lady in Springfield, Massachusetts, who was attended in her labour by one of the most eminent of our New England practitioners. I presume it was an example of spontaneous inversion at a somewhat remote period after confinement, for the character of the physician is a sufficient guarantee that it could not have resulted from any mismanagement on his part, nor could it have occurred spontaneously at the time of his attendance without being detected by him. A few weeks after this lady's delivery her physician went abroad. Some months afterwards she called another physician, who treated her for menorrhagia. She did not improve, and by-and-by a consultation was held, when the case was ascertained to be one of inversion.

She was then etherized, and efforts at reduction were made and continued for an hour without effect. Two or three weeks after this I was sent for; the patient was etherized as before, and I was able to reduce the inverted uterus to its normal relations in less than five minutes. This was in May, 1860, about twelve months after the labour. The medical brethren present gave me great credit for the facility with which the operation was performed. But its speedy accomplishment was a little accidental. Introducing the left hand into the vagina, I grasped the uterus, and soon restored it to the position represented by fig. 1, where the fundus is shown as just within the os uteri. At this moment I changed my hold on the uterus, and, rather by accident than design, deeply indented the right cornus (*a*) with the thumb of the left hand; the fingers compressed the opposite side of the organ (*b*), and, while the thumb pushed the tissue in which it was imbedded upwards, the fingers rather acted in a contrary direction on the opposite side; and, to my great surprise, the uterus jumped, as it were, out of my hand, assuming its proper normal position. I certainly had not the remotest idea of restoring the organ under a half-hour's effort.

Judging from the experience of these two cases, the great difficulty seems to be in passing the fundus through the os internum. It was easy enough in each instance to reinstate the organ to the condition represented by the diagram (fig. 1). That being the case, I should infer that there were no peritoneal adhesions to prevent the completion of the operation.

There is one point that I wish to dwell on particularly.

Those who follow the plan of my distinguished countryman, Professor White (whom I have imitated), would do well always to make counter-pressure with the outer hand over the abdomen, as represented in this diagram (fig. 2).

Fig. 2.

In pushing the uterus upwards by the hand in the vagina there is certainly some danger of lacerating the vagina and tearing the uterus asunder from its attachments at the posterior cul-de-sac. Counter-pressure will obviate that danger. Another advantage of counter-pressure is that the fingers pushed down on the uterus, as the cervix is doubled on itself, assists very materially in dilating that portion through which the fundus is to be forced upwards.

But suppose, after proper efforts, we fail to restore the uterus, should we amputate it?

Before taking this last resort I would, rather than amputate, make longitudinal incisions from the os tincæ along the cervix to a point beyond the os internum, for the purpose of facilitating the process of reduction.

I would make at least three, one on each side, as represented in this diagram (fig. 3, *a*, *a*), and another, similar, on the posterior surface. I say posterior, only because it would be easier to make it there than on the anterior surface, if the patient be on the left side, with my speculum as it is ordinarily used. The object of these incisions would be to divide the circular fibres of the uterine tissue, and thereby to remove one of the principal barriers to the reduction of the fundus.

Fig. 3.

I hope I have said enough to show that we should not resort to the operation of amputation till we have tried persistently and patiently every possible means for reinstating the organ to its normal position.

Mr. Sidney Turner was unable to speak of chronic inversion of the uterus from practical experience; but its reduction seemed to him very much to resemble that of hernia by the taxis. Dr. Marion Sims had told them that the structure of the tumour is elastic, and that it is congested with blood. To reduce it, then, the best plan would suggest itself to be—first, by grasping the tumour largely with the hand, and keeping up a steady and equable pressure on it, to diminish the quantity of blood, and so reduce its bulk; then, by a kneading process, to return that part first which came down last; and not to push blindly at the fundus, which makes the cervix double on itself. As a probable cause of inversion, besides that of traction on the cord from *below*, another equally bad plan of procedure in removing retained, and may be adherent, placentæ, is practised by some medical men, who tell their patient to cough at the same time, so giving an impulse to the fundus from *above*. These combined circumstances acting on

a flaccid uterus must have been the cause of more than one inversio uteri.

Dr. HALL (Brighton) concurred in the opinion of the last speaker, viz., that in endeavouring to replace the inverted uterus we should first try to diminish the bulk of the organ by such manipulations and pressure as would tend to lessen the quantity of blood in it; and for this purpose he thought that, in addition to the use of the air-pessary, as advised by Dr. Tyler Smith, we might with advantage introduce into the vagina a bladder partly filled with ice in small pieces, the cold and pressure arising from which would reduce the bulk of the inverted organ, and thus facilitate its replacement. He instanced the beneficial effect of a stream of cold water poured from the spout of a jug upon a case of paraphimosis, where division of the constriction was proposed as the only means of relief. In the course of a few minutes the swelling of the penis was so reduced as to allow of the organ being easily restored to its normal condition. Gentle manipulation at the *point of constriction* was the true method to overcome it, whether such existed behind the glans penis, as in paraphimosis, or at the os internum, as in an inverted uterus. The employment of the taxis in constricted hernia, as observed by the previous speaker, was based upon this principle also.

Dr. BARNES asked Dr. Sims whether he had observed the condition of the uterine fibre as to contraction or flaccidity when inversion took place, or when he was attempting reduction. He thought it right to state, on behalf of an absent Honorary Fellow, Dr. McClintock, that Dr. McClintock had fully explained the analogy between inversion of the uterus and hernia, and had even applied this view to practice in reducing the inversion. He showed the error of applying the chief pressure to the fundus; to reinvert this first only doubled in the walls of the uterus, forming a double thickness, all of which had to pass through the narrow os internum; whereas, by gradually compressing the neck of the tumour, and returning that part first which came out last, he exactly imitated the process of reducing a hernia, and never opposed more than the single thickness of the uterine wall to the constriction of the os. With regard to Dr. Tyler Smith's method of reinverting chronic inversion, he believed the air-ball acted by constant pressure against the contracted cervix, which in the end wore out the resistance, until, the os being sufficiently dilated, the uterus went back. Pressure also probably diminished the bulk of the tumour, by pressing out fluids from its texture. He had recorded a third case, in addition to Dr. Smith's original one and Dr. West's, of complete success by this method, taken from a German author. Dr. Smith, he believed, attributed inversion to an antiperistaltic or perverted contraction of the uterus. But he (Dr. Barnes) was disposed to concur with Professor Laggati,

of Milan, who contended that perfect flaccidity of the uterine fibres was the necessary condition. This was confirmed by the history of many cases, which showed that the accident occurred when the patient was in the erect posture, immediately after expulsion of the child, and using some exertion, which drove the superincumbent intestines upon the fundus uteri; this, being flaccid, yielded and went through the flaccid cervix. This view was confirmed by a case of post-mortem delivery, followed by inversion of the uterus, recorded by Dr. Alfred Taylor, in the last volume but one of 'Guy's Reports.'

Mr. I. B. Brown, jun., suggested that, as the President had said that relaxation of the uterine tissue was necessary to the reduction of the inverted uterus, ice would have a contrary effect, and that, instead of the air-ball of Dr. Tyler Smith, an india-rubber ball, filled with warm water (similar to the admirable apparatus invented by the President for cases of placenta prævia) would answer much better. The warm water would relax the tissues, while the pressure would control hæmorrhage.

CASE OF EXTREME DISTORTION OF THE PELVIS; CRANIOTOMY; CEPHALOTRIPSY; CÆSAREAN SECTION.

By Robert Greenhalgh, M.D.,

PHYSICIAN-ACCOUCHEUR TO ST. BARTHOLOMEW'S HOSPITAL, AND LECTURER ON THE DISEASES OF WOMEN AND CHILDREN; CONSULTING PHYSICIAN TO THE CITY OF LONDON LYING-IN AND SAMARITAN HOSPITALS, ETC. ETC.

I am induced to lay the following case before the Society as remarkably illustrative of the great difficulties and dangers of delivery in cases of *extreme* distortion of the pelvis.

At four o'clock in the afternoon of the 26th of September I was requested by Mr. Dewsnap, jun., to visit Mrs. L—, æt. 28, who was greatly distorted by rickets.

On my arrival I learnt that her first labour, which was at term (March, 1864), lasted upwards of fifty-four hours; that twenty-four hours after its commencement the head of the fœtus was perforated, and, after violent and prolonged

efforts at extraction, separated from the body, which could not be removed for twenty-two hours; that the placenta was retained for eight hours, and that ever since her delivery she had been the subject of a large vesico-vaginal fistula.

At the time of my visit she was in good health, and had completed the eighth month of her second pregnancy. Labour had set in spontaneously about two hours previously; the pains were feeble and far apart; the os uteri the size of a shilling, the membranes unruptured, and no presenting part to be felt; the fœtal heart was distinctly heard slightly to the left of the umbilicus. A cursory examination convinced me that the pelvis was greatly distorted. Anxious to avoid undue interference, and more especially as the vagina was extremely unhealthy, irritable, and tender, it was determined to defer a more rigid examination until active labour should set in, and assistance be imperatively demanded.

At four o'clock in the afternoon of the following day I and Mr. Dewsnap again visited our patient, when we found that the pains were frequent and severe, the os uteri fairly dilated, the membranes ruptured, and the left foot presenting at the brim. She was now put fully under the influence of chloroform by Dr. Balls, and a careful examination of the pelvis made, when we arrived at the following results:—That the outlet and cavity were below the average dimensions, and that there was little, if any, more space than an inch and three quarters in any part of the antero-posterior diameter of the brim. After mature deliberation it was agreed, notwithstanding the extreme distortion, that we should endeavour to effect the delivery per vias naturales; accordingly, first one foot, then the other, was pulled down and secured by pieces of tape; subsequently the breech and arms were extracted with great difficulty. Firm and steady traction downwards and backwards was made upon the body by Mr. Dewsnap, with the view of bringing the base of the skull within reach of the finger, but without any result. I now succeeded, with much dif-

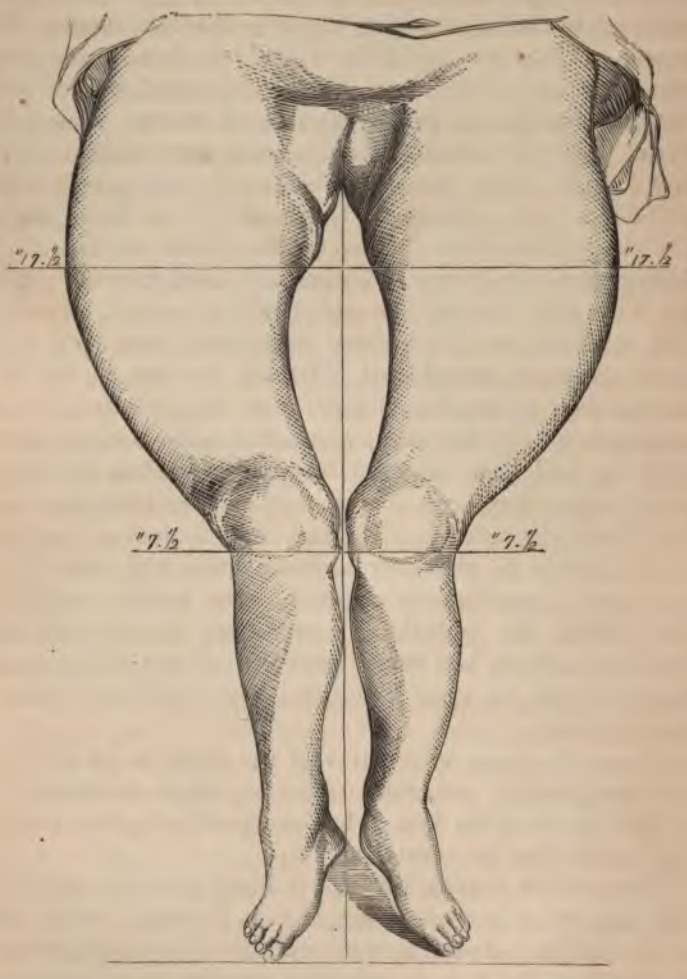
ficulty, in passing the perforator beneath the integuments of the fœtal neck into the foramen magnum, but with so little effect, as far as the reduction in the size of the head was concerned, that I subsequently directed the instrument to the left of the base of the skull, into which it penetrated, giving exit to some cerebral substance. I now introduced Dr. Simpson's cephalotribe on either side of the pelvis, with which I succeeded in obtaining a firm grasp of the head, which I reduced to the smallest possible dimensions. At this stage I directed Mr. Dewsnap to pull firmly and steadily on the body, while I endeavoured to extract the head. After the most persevering endeavours for about twenty minutes the body unfortunately separated from the head, and at the same time the cephalotribe slipped. The patient now became alarmingly collapsed, but in about ten minutes rallied. I, and subsequently Mr. Dewsnap, tried to introduce a hand into the uterus, with a view of facilitating the extraction of the head, but, owing to the extreme narrowness of the brim, we failed in our attempts. But two courses were now open to us, either to leave the patient in her present condition or to perform the Cæsarean operation. Notwithstanding the unfavorable condition of the patient, we one and all felt that the latter desperate alternative would be preferable to leaving her undelivered; consequently no further time was lost, and I proceeded to perform that operation. Having made the usual incision in the course of the linea alba through the abdominal parietes, I came down upon the peritoneum, which was protruded through the wound by some blood beneath it, clearly indicating that some internal rupture had taken place. I now cut through the peritoneum and passed my finger into the opening, which I enlarged to the extent of six inches, giving exit to some fluid blood. I and Mr. Dewsnap carefully examined the uterus, which was firmly contracted, but could not discover any trace of a rent. Having made an incision, from four to five inches in length, through the body and in the long axis of the uterus, I introduced my hand into its cavity, when, to my surprise

and dismay, I found the head had escaped into the abdomen, and was lying beneath the diaphragm, on the left side, from which locality it was speedily removed. There was some difficulty in extracting the placenta, which was firmly attached to the upper and posterior wall of the body of the uterus. There was but little blood lost during and after the operation. The edges of the abdominal wound were brought together by twelve interrupted sutures, secured by broad strips of adhesive plaster, pads, and bandage. All soiled linen being removed, the patient was placed comfortably in bed. She speedily recovered from the effects of the chloroform, which she had inhaled about two and a half hours, when two grains of opium were administered. Half an hour after delivery she complained of nausea, otherwise her condition was much more satisfactory than could have been reasonably anticipated. During my visit on the following day, twenty-four hours after the operation, I was informed by Mr. Dewsnap, who had seen her several times, that she had been troubled by vomiting during the night, that she had dozed occasionally, had had but little pain, and no febrile disturbance. I found her somewhat restless, being anxious to shift her position; pulse 120, skin warm and moist, countenance cheerful, some lochial discharge. She wished for something better than brandy and ice, which was all she had taken since her delivery; accordingly good beef tea, in small quantities, with bread and butter, were ordered.

About six hours after my visit she began to be restless, and symptoms of prostration came on, which increased up to one o'clock of the 28th, when she quietly expired, thirty-one hours after the operation.

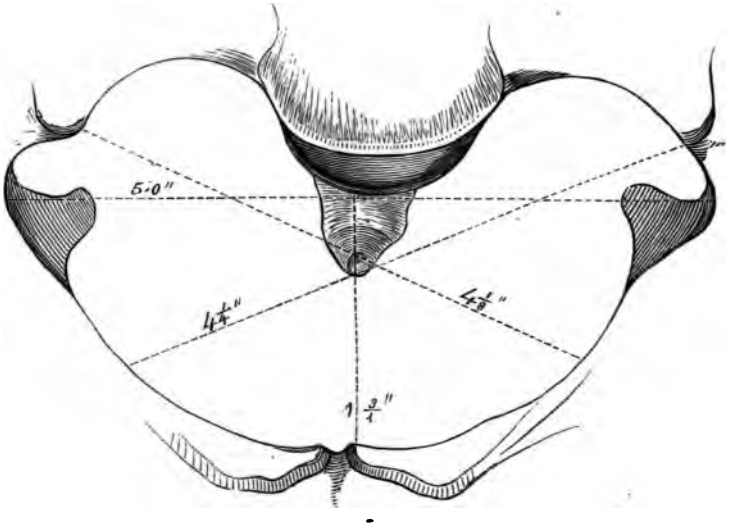
Post-mortem examination, thirty-nine hours after death, in the presence of Dr. Greenhalgh, Messrs. Dewsnap, Brown, and Hemborough.—As the body lay upon the table the distortion, especially of the femora and tibiæ and fibulæ, was most remarkable, as may be seen by the sketch made at the time by Mr. Brown. On removing the bandages and strapping, the edges of the abdominal wound were found in close apposition,

but nowhere united. The peritoneal cavity contained a very small amount of bloody serum. The uterus, although flaccid, was well contracted and empty. The incision through its walls



was reduced to two inches and three quarters, and extended within an inch of the fundus; the wound was gaping. There was a jagged rent running upwards and backwards in an

oblique direction, commencing at the vesico-vaginal fistula on the left side and passing through the vagina and neck of the uterus. The pelvis was removed, and when divested of its soft parts was found to be remarkably heavy and greatly distorted, as is seen in the accompanying drawing.



Admeasurements.

From anterior superior spinous process to opposite side	10	inches.
External antero-posterior diameter . .	$4\frac{3}{16}$	,,
The brim:		
The transverse diameter	5	,,
The conjugate diameter, left side . .	$1\frac{3}{4}$	,,
,, ,, ,, right ,, . .	$1\frac{7}{8}$	,,
The oblique ,, ...	$4\frac{3}{8}$	,,
The outlet:		
The transverse diameter	$3\frac{5}{8}$	,,
The antero-posterior ,, . . .	3 to $3\frac{1}{2}$	,,
The oblique ,, ...	$3\frac{5}{7}$	,,

The cavity:

From the centre of the sacrum to the upper part of the pubic arch . . . . $2\frac{3}{4}$ inches.

The depth from the top of the sacrum to the coccyx . . . . . $4\frac{3}{8}$ „

Now, it might be asked why I attempted to deliver *per vias naturales*, knowing, as I did, that the pelvis generally was much distorted and that no part of the antero-posterior diameter of the brim measured two inches. I was induced to make the attempt on the following grounds:

1st. The patient had, during her first labour, been delivered *per vias naturales*.

2ndly. The child was premature.

3rdly. It was a footling presentation.

4thly. The child was dead.

And I must confess that I was most anxious, as I always have been, to avoid the Cæsarean section, which I have now performed six times, because it has been said that I have sought every opportunity to deliver by that operation.

The experience I have derived from this and other cases of craniotomy and extraction in *extreme* distortion of the pelvis has determined me for the future never again to attempt delivery *per vias naturales* unless there is fully two inches in some part of the antero-posterior diameter of the brim.

I believe that craniotomy and extraction by the crotchet or cephalotribe in cases of *extreme* deformity of the pelvis is more difficult and probably more fatal to the patient than the Cæsarean section, and moreover by the latter operation, if timely performed, there is every probability that the child's life may be spared.

NOVEMBER 1st, 1865.

Dr. BARNES, President, in the Chair.

Present—46 Fellows and 10 visitors.

The following gentlemen were elected Fellows of the Society :—Dr. Fly Smith, 10, Kensington Park Terrace; Dr. Charles Kernot, 3 and 4, Chrisp Street, Poplar.

The PRESIDENT announced that the Council had resolved to hold a Conversazione in March next, for the purpose of exhibiting a full collection of instruments used in obstetric practice. He observed that the invention and modification of instruments served to mark the advances made in science and art; that it was a matter of great interest to exhibit and verify the original forms of instruments, and the instruments used in different countries and by different practitioners. Such an exhibition could not fail to prove instructive and attractive, as illustrating the history and the present application of instruments. Invitations would be issued to all the principal home and Continental professors and institutions; and the President invited all the Fellows to assist in the work.

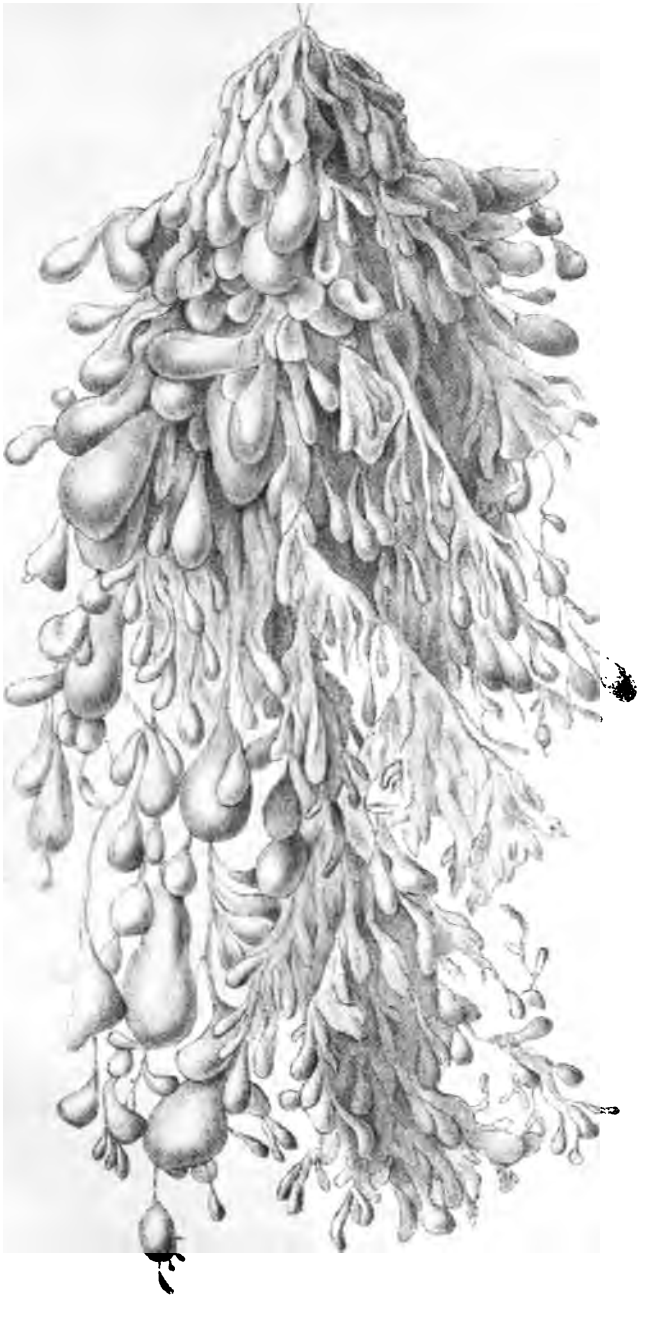
Dr. BARNES exhibited a monstrous fœtus brought to him by Mr. Thane, of Canonbury. Not being dissected, the character of the deviations from nature could not be described. It presented, however, one feature very common in monstrosities, namely, distortions of the limbs, resulting from pressure of the walls of the uterus. It seemed that the

defective vital force of monsters disabled them from resisting the effects of pressure, as the normal fœtus did.

Dr. Barnes also exhibited a voluminous fibroid tumour, weighing 1 pound 13 ounces, which, with the assistance of Dr. Hicks, he had removed from the uterus of a lady a month ago. It partly occupied the pelvis, but the greater part rose above the symphysis into the abdomen. It was removed partly by elongating it by transverse or spiral incisions, and at last it was enucleated and brought away entire. The patient made a perfect and uninterrupted recovery.

Dr. Russell, of St. Albans, laid before the Society the particulars of a case of hydatiform degeneration of the ovum.

The patient, a Mrs. A—, æt. 45, and having had eight children previously, was first seen by Mr. Webster, a medical practitioner in the same town, in July, when she appeared to be suffering from all the early symptoms of pregnancy. On the 17th of October she was seized with severe flooding, and pains resembling those of labour. About 5 p.m. Dr. Russell was called in to see the case, and found the patient very prostrate from hæmorrhage. Having administered some stimulants, he proceeded to make an examination. The os uteri was dilated about the size of a five-shilling piece, and expulsory pains continued at intervals of from five to ten minutes. A soft, pulpy mass was felt protruding, and Dr. Russell, diagnosing it as a case of placental presentation, proceeded to dilate and introduce the hand, with the object, as he thought, of effecting the delivery of a fœtus. On doing so, the uterus for a few minutes violently contracted on the wrist. On its subsidence he continued to pass the hand round the walls of the uterus until it reached the fundus, and was surprised at not being able to discover a fœtus; but his hand immersed, as it were, in a mass of coagula. He removed the contents of the uterus, which were sufficient to fill a common utensil, and found to be of the character presented in the accompanying drawing (Plate V). The uterus immediately



Dr Westmacott del.

contracted, and the woman went on well until the 30th, when she had slight hæmorrhage, which, however, soon yielded to treatment. The abdomen, previous to delivery, gave the appearance in size of seven or eight months' pregnancy. The urine was tested some days afterwards, but no albumen was discovered.

A CASE OF OVARIOTOMY IN WHICH THE PEDICLE WAS TIED AND RETURNED, AND THE LIGATURE REMOVED IN FORTY-EIGHT HOURS.

By J. H. Aveling, M.D.,
SENIOR MEDICAL OFFICER TO THE SHEFFIELD HOSPITAL FOR WOMEN.

Mrs. A. W—, æt. 45, keeps a small shop and mangle, came into the Sheffield Hospital for Women, suffering from an ovarian tumour. She has been married twice, and has two children. The eldest is now twenty-five, and the youngest twenty-two. Her second marriage took place in February, 1864. Her general appearance and complexion are good. There are, however, a few small boils on the abdomen, and slight œdema of the ankles.

The measurements are—1. Girth at the umbilical level, forty-one inches. 2. From ensiform cartilage to umbilicus, nine inches. 3. From umbilicus to symphysis pubis, nine inches. 4. From right anterior superior spine of ilium to umbilicus, nine and a half inches. 5. From left ditto to umbilicus, nine inches.

There is too much distension to make out whether adhesions exist or not. Fluctuation is very distinct. The uterus is pushed over to the left side, and can only be moved slightly. The length of its cavity is three and a half inches. The catamenia appears every three weeks, but the discharge is small in quantity. It was entirely suppressed for three months in 1864. Finding herself getting stouter, the patient then

thought she might be pregnant; but as it hurt "her belly to lift," she concluded something must be wrong, and sent for her medical man, Mr. Parker, who diagnosed ovarian tumour. From that time to the present she has continued to increase in size. Her breathing is very laboured, and accompanied by a troublesome cough. She sleeps on her right side, but is most comfortable when sitting nearly upright.

August 3rd, 1865, with full consent of the patient, the operation was performed. Drs. Jackson and Keeling and Messrs. Gillott and Sharp were present, and rendered valuable assistance. An incision was made between the umbilicus and the pubis, five inches long, commencing an inch below the umbilicus. As soon as the cyst was reached it was tapped, and the fluid withdrawn without passing the hand into the abdomen. No adhesions existing, the sac was drawn out easily. The pedicle, which was short and about four inches broad, was transfixed with a needle carrying a double thread. The two ends of each ligature were then brought up together on either side, and drawn through two iron-wire coils. Each coil had fitted upon its end a cross-bar, and round these cross-bars the ligatures were secured after they had been drawn sufficiently tight to compress the vessels. The pedicle was then placed in the hook of my polyptrite and crushed through. As there was no hæmorrhage it was returned at once *in situ*, and the wound closed with iron wire sutures. The heads of the two coil-

clamps were left protruding from the lower angle of the incision.

The tumour consisted of five cysts, communicating with one another, and of a colloid mass about the size of the placenta. The cysts contained twenty-one pints of fluid.

August 4th.—Patient comfortable. Has taken food well. Pulse 84. No abdominal tenderness.

5th.—Has pain caused by flatulence. Pulse 80. The ligatures were unwrapped from the cross-bars, the coils removed, and the ligatures drawn out.

6th.—The wound is healed, with the exception of a small aperture the size of a quill, through which the coils passed. The sutures were removed, and plaster put on instead. Pulse 85.

8th.—Has had a feverish attack, followed by an eruption which extends over the forehead, arms, chest, and abdomen. She is restless and uneasy. Pulse 95.

10th.—Eruption fading. Pulse 80. The slight discharge which has continually escaped from the small opening has ceased.

From this time the patient had not an unfavorable symptom, and, after two or three weeks of good living, she was discharged cured.

October 23rd.—The patient walked to the hospital this morning, a distance of two miles, and says she is able to attend to her shop, and, now and then, to take a turn at the mangle.

The coil-clamp, which is figured in the preceding sketch, will probably be found most useful in cases where the pedicle is short, as by its use all dragging may be avoided. In the foregoing case two clamps were used. One would probably have been quite sufficient. They may be obtained from Messrs. Hutchinson, Duke Street, Sheffield.

Mr. Spencer Wells said that no one method of dealing with the pedicle could be applicable in all cases of ovariotomy. A long pedicle was dealt with so successfully by the clamp that he desired no better method; but it was still doubtful what was the best mode of proceeding when the pedicle is short. Tying it and

cutting off close to the ligatures, and returning it with the ligatures, also gave excellent results in persons of good condition. But in feeble persons, where copious serous effusion might be expected, and it appeared desirable to maintain an opening for drainage, the plan of the earlier ovariotomists, of leaving the ends of silk or twine ligatures hanging out through the wound, was so unsuccessful that the apparatus of Dr. Aveling would probably prove of great advantage in cases of short pedicle in weak patients. Ovariotomy was an operation still in its infancy, and anything which seemed likely to improve any of its steps was worthy of investigation and trial.

Dr. Marion Sims said that the clamp was a great improvement on the ligature. He thought Mr. Baker Brown's plan of severing the pedicle by the actual cautery promised great results. He viewed Dr. Aveling's method with favour. He always used a silver wire, and left it to be sacculated. He said the distal end of the severed pedicle did not slough where the wire was applied. The wire became embedded and hidden in its tissue. He saw this in a case in which he had applied the wire for M. Nelaton, whose patient died five days after the operation. His countryman, Dr. Peaslee, had proven that the stump of the pedicle did not slough even when tied with a common ligature, for he had made three *post obit* examinations, in all of which this fact was verified. He thought the plan of dealing with the pedicle was still in a transition state; and he hailed with pleasure every improvement in this direction, for from this he expected a still greater reduction in the mortality of ovariotomy.

Dr. Aveling said that he was not particularly wedded to the use of the coil-clamp in all cases, but that he thought it would be found of service in cases where the pedicle is short. By its use the injurious dragging caused by the ordinary clamp is avoided. He was obliged to Mr. Spencer Wells and Dr. J. Marion Sims for the favorable way in which they had spoken of it.

A DIFFICULT CASE OF LABOUR CONNECTED WITH A NON-EVOLUTED AND HYPERTROPHIED STATE OF THE CERVIX UTERI.

By George Roper, M.R.C.S.E.,
SURGEON TO THE ROYAL MATERNITY CHARITY.

On the 16th of September, 1865, I was called by a midwife to see A. E—, æt. 37, in labour at full term with her eighth child. There had been considerable flooding; the liquor amnii had been discharged thirty hours, and labour had commenced some hours before. She was in a very weak and exhausted condition, and the labour-pains had become feeble and infrequent. I found the cervix uteri very large and unevoluted, and projecting down low into the vagina. The os externum was sufficiently large to admit the hand, but the os internum would not allow this. The occipital part of the head presented above the brim, and the edge of the placenta, lying detached, could be felt within an inch of the os internum. I ordered that she should be kept quiet, and prescribed the free use of brandy, beef tea, and eggs, and appointed to see her again in six hours if not sent for before.

At the end of this time I saw her again; she was still very exhausted; the skin was cold and perspiring profusely; the pulse 120 and very feeble; the os internum had undergone some dilatation, so that by care the hand, with some little difficulty, entered the uterus. From the occipital part of the head presenting, the child was so doubled into a ball-like form, by the face having been bent towards its abdomen, that I could not succeed in getting hold of one of the feet. Ergot had been given, and the liquor amnii had now been discharged thirty-six hours, so I abandoned the attempt to turn, and as the funis was pulseless I had no doubt about the propriety of perforating; this was easily done through the occiput, and the brain was well broken up; a good hold of the cranium was obtained posteriorly with Barnes's forceps, and the head, which was above the brim, readily came down into the pelvis

by gentle traction. As much pressure was made on the os internum as was thought proper; the head and the uterus could easily be drawn down together, so that the edge of the os externum protruded from the vulva; the cervix was thus brought fairly in view; it was of a pale rose colour, and free from œdema, and the effects of the attempt to draw the child through it could be well observed. After some perseverance, without much progress in dilatation, I shifted the forceps anteriorly, but in this position failed to obtain a good hold. When traction was discontinued the head with the cervix uteri ascended freely up into the pelvis. I now tried the straight Dublin forceps, which, from being small and slight, would occupy but a small space, and I thought a more uniform pressure would be made on the circumference generally of the os uteri than by the craniotomy forceps, which seemed to produce more pressure at the point where they were applied than on the os generally, care being taken that the structures of the head, and not the instruments, were made the immediate means of expansion; so I applied the ordinary long curved forceps, and, by continued, gentle, and steady effort, the head was drawn through the os. Some little obstruction was caused by the shoulders.

I was informed that this patient had been delivered of her last child by Dr. Barnes, under circumstances of difficulty, and he has kindly furnished me with the following report of the case, accompanied with a drawing:

"Mrs. S—, 18th January, 1864.—*Pelvic tumour obstructing delivery; craniotomy; turning.*—This patient has had several children at term; last born prematurely two years ago. Has latterly before and during pregnancy suffered from prolapsus uteri, and has worn a napkin to keep it up. Midwife sent for me, finding labour impeded, as she said, by 'protrusion of the womb.'

"I found a largely hypertrophied cervix, with thick lips, just within the vulva; when pain came on this was extruded. The head lay at the brim of pelvis, above the os uteri internum, which was only partially open, and quite four inches distant from the os uteri externum. Besides this abnormal condition

there was a large, soft, but firm and smooth tumour, filling all the hollow of the sacrum, rising above the brim, narrowing the conjugate diameter to two and a half inches, and descending as low as the coccyx, and spreading out on either side so as to occupy all the posterior half of the pelvic cavity. This was more manifest by examination by rectum. This tumour bulging forward into the pelvic cavity, pushed up the lower segment of the uterus, prevented descent of the head, and compressed the two sides of the elongated cervical canal together. The tumour seemed fixed, so I did not attempt to push it up above the brim. Regarding the soft structure of the tumour, I thought it possible the head might come down by aid of forceps. Applied forceps, locked well; but reasonable effort failed to advance the head. Perforated; my new craniotomy forceps not being at hand, tried crochet; head made but little progress, and, as it clearly would have involved considerable time and risk of bones being too much broken up to complete extraction, I did not persevere, but resorted to turning; chloroform. Four fingers entered the pelvic cavity, and passed the os externum without much difficulty; but the os internum was rigid, and barely admitted the middle of the cone formed by the four fingers. Here also obstruction was added from without by the tumour. I therefore pushed the head firmly upwards and to the left, and by the hand outside succeeded in depressing the breech, so that a knee came within reach; a foot being brought down, evolution was completed by pushing the head away from the brim by the hand outside. Extraction at first difficult during the gradual yielding of the os internum to the breech; head came without much difficulty. Child male, large; skin desquamating generally; scrotum red from post-mortem infiltration. Uterus contracted under pressure; placenta withdrawn. No hæmorrhage. Patient had suffered pains for several days; it is probable that labour had actually endured two or three days, but from impossibility of descent of head it had lingered, the child in the mean time dying. Some days after labour a discharge of 'thick matter' set in, and continued.

"On the 9th of February, when I saw her, the tumour had

then diminished in size; no pain; the tumour was also softer; a portion could be felt by pressing the hand firmly towards the promontory of the sacrum from above the pubis. The patient recovered without any severe symptoms. This diagram was entered in my note-book as representing the idea formed at time of the seat of the tumour (probably ovarian), and of the hypertrophy and elongation of the cervix uteri."

a, the tumour.

For two days after her last delivery she progressed favorably. She was then seized with severe shivering, followed by a hot skin, quick pulse, and a copious eruption of herpes about the mouth; there was no abdominal tenderness. I examined her several days after delivery per vaginam, without being able to detect any mischief about the uterus or parts within the pelvis; the cervix was still large and elongated; there was a fetid sero-purulent discharge, but this was not profuse. She died fifteen days after delivery. During this time she had frequent fits of shivering as severe as the rigors of an ague; the tongue became dry and brown; there was much diarrhœa; a quick, full, running character of pulse; and on the fourth day before death there was pleuro-pneumonia at the base of the right lung.

Dr. Barnes saw her in consultation with me, and concurred with me in the case being one of a pyæmic condition, as there was then no severe local disease to cause so much constitutional disturbance. The drawing correctly represents the condition of the parts at her last labour, except the tumour.

Mr. James Stedman, who kindly gave me his aid in delivering her, did not detect anything in the shape of a tumour, and the facility with which the head could be drawn down into the pelvis, so that the cervix uteri protruded, demonstrated that there could be no obstruction within the pelvic cavity. The nature of the tumour which was present at her former labour, as represented in the drawing by Dr. Barnes, must be questionable; it could not have been of a persistent kind, or it would have been there at her last labour. Might it not have been a large, dense thrombus in the recto-vaginal septum, or behind the rectum. Dr. Barnes says it was "large, soft, but firm and smooth;" such would be characteristic conditions of a thrombus; and when he saw her three weeks after delivery he describes it as being "smaller and softer;" this is not unlike a thrombus undergoing absorption. As the os and canal of the cervix expanded there was no irregularity in its circumference to indicate cicatrization or morbid deposit of any kind in its texture; no hardness of structure, but a simple, uniform enlargement of the entire cervix. This case presented one of the greatest obstetric difficulties I have met with. The patient, from loss of blood (the case being one of partial placenta prævia), and the length of time she had been in labour, was in a state of serious exhaustion when I commenced to deliver her, and several times it was thought desirable to abandon attempts at delivery in consequence of a belief that she was actually moribund. The resistance of the os internum constituted the chief difficulty. One of two ways of proceeding could only be adopted.—exvisceration and dismemberment of the fœtus; or craniotomy (with or without turning), with a certain amount of force necessary to extract the body entire. The first method must necessarily be long and severely trying, scarcely to be endured by the nearly worn-out powers of life. In the second, with a more speedy

delivery, there is the risk of injury to the uterine structures by a needed force, however judicially applied. In the present case the latter course was pursued, and, although no laceration nor fissuring happened, it is presumed a degree of bruising and straining of the cervical textures must result, such as would cause suppurative action and consequent pyæmia, the more likely to occur after a labour complicated with placenta prævia. I regret that I could not succeed in obtaining a *post-mortem* inspection of this case.

ABSTRACT OF A PAPER

ON PROCIDENTIA UTERI,

READ BY

J. MARION SIMS, M.D.,

HONORARY FELLOW OF THE OBSTETRICAL SOCIETY.

WHENEVER the cervix uteri passes through the mouth of the vagina we call it a procidentia, whether it be to a slight or a great extent.

Several separate and independent conditions must conspire to produce a result so opposed to the designs of nature. Thus, there must always be a broad pubic arch, with very divergent rami and a relaxed perineum; and then the axis of the uterus must be turned back in a line with that of the vagina and the pelvic outlet; in other words, there must be a retroversion. With the uterus anteverted, a procidentia is utterly impossible, be the attendant circumstances what they may.

In an old procidentia the vagina attains enormous proportions, in consequence of its being constantly expanded by the distending power of its hernial contents.

Fig. 1 is from a photograph of a patient of Dr. Thierry-Meig, in Paris, and represents a cystocele as the first stage of procidentia.

Sometimes we find the intra-vaginal cervix elongated, but

oftener the supra-vaginal. Occasionally we see a complete descent of the whole uterus through the vulva.

But while we only occasionally find a procidentia thus associated with a uterus, under or even of normal size, we often

Fig. 1.

find it where there is hypertrophy of some part of this organ.

In cases of cervical elongation we often find the utero-cervical canal four or five inches deep. This elongation is evidently secondary. I believe it to be a sequence of the procidentia. If the body of the uterus passes out of the pelvis, there is no supra-vaginal elongation; if not, there is.

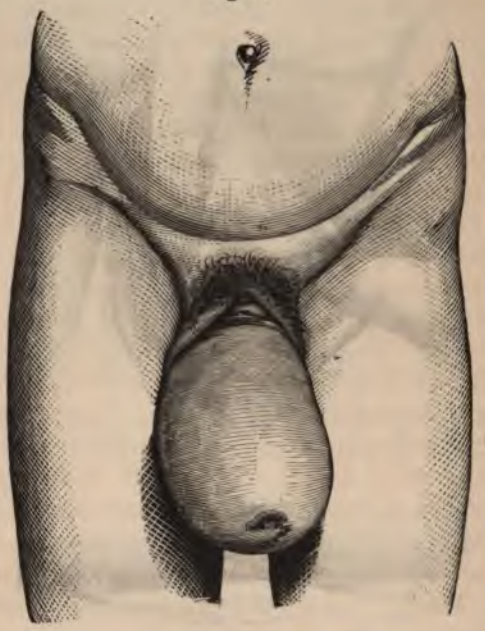
When the procidentia is due to a mass of tumours filling the pelvic cavity, and crowding the uterus downwards, as I have seen in several instances, we cannot, I regret to say, promise much relief.

Fig. 2 represents a procidentia of more than twenty years'

standing, in a woman nearly seventy years of age, whose pelvis was filled with a number of small fibroids of bony hardness.

Huguier has written extensively on procidentia uteri, and I believe he was the first to point out the distinctive charac-

Fig. 2.



teristics of its anatomical peculiarities. He found elongation of the cervix in all cases, either above or below the insertion of the vagina; and he suggested and performed amputation of the neck of the uterus in every case, and with great success.

I amputate the cervix only when its lower segment is too large or too long, and projects so far into the vagina as to present a mechanical obstacle to the retention of the uterus *in situ* when replaced. If there should be elongation of the infra-vaginal cervix, amputation is the remedy; but we often find procidentia without any extraordinary elongation of the

infra-vaginal portion of the cervix. There is then nothing to amputate.

In these cases Mr. Baker Brown, Dr. Savage, and others, contract the vulvar outlet by the perineal operation; but generally I prefer to narrow the vagina above, which usually very effectually retains the uterus in something like a normal position within the pelvis.

The idea of narrowing the vagina is by no means new. I suppose we may justly claim it for the great Marshall Hall. However, I do not think the operation ever succeeded till my own day, and this success is due wholly to metallic sutures.

The author then described a case in which he observed that the descent was not by the protrusion of the cervix uteri, but invariably by a prolapse of the anterior wall of the vagina, which always preceded the cervix, and drew down the uterus. He noticed also that, by pinching up the anterior wall of the vagina into a longitudinal fold, the parts had no tendency whatever to come down; and that it was impossible for the patient to force them down if the anterior wall of the vagina was prevented from descending. Hence the idea of removing the redundant portion of the anterior wall of the vagina; but "it did not occur to me to operate simply by removing strips of vaginal mucous membrane. I seriously proposed to this lady to make a complete vesico-vaginal fistula, by removing at one blow, as it were, a large portion of the base of the bladder with the anterior wall of the vagina. She agreed to it, and it was adopted."

Proposing to excise the anterior wall of the vagina, I hooked it up with a tenaculum, pulled it well towards the posterior wall, and then grasped the base of the mass thus elevated with a pair of curved forceps made for the purpose, acting on the principle of Ricord's phymosis forceps, which held the parts firmly embraced, while with scissors cutting under the forceps I removed, at once, a very large portion of the anterior wall of the vagina. The portion removed measured two inches and a half transversely, by two inches and five eighths longitudinally, and was very thick. The chasm made by this operation was fearful, the

lateral retraction of the divided edges being so great as to present at a superficial glance some difficulty in bringing them together by sutures. There was, however, no trouble whatever.

Fig. 3 would represent a side view of one blade, *a*, of the forceps, as it grasped the portion *c*, to be removed. The bleeding was not profuse; but I at once rapidly filled the

Fig. 3.

chasm with cotton, to stop the hæmorrhage by pressure. A few minutes sufficed for this; and then the tampon was removed for the purpose of closing the edges of the opening by transverse sutures. My surprise was equalled only by my delight, when I found that I had not succeeded in doing what I intended; for instead of excising the base of the bladder with the anterior wall of the vagina, I had, by the tenaculum, simply raised the hypertrophied vaginal tissue up between the blades of the forceps, luckily separating it from the lining membrane of the bladder, which remained intact. Thus, by a mere accident, the operation was really far better than if I had succeeded in accomplishing what theoretically I proposed to do.

Fig. 4 would represent about the relative proportion of vaginal tissue here removed. The lateral edges were brought together longitudinally by silver sutures passed transversely, as represented in the diagram. She was soon well, and is so to this day. The operation was done nine years ago. This

method of operating was continued till 1858, when an elderly woman, with an enormous procidentia of fifteen or twenty years' standing, was sent to the Woman's Hospital by Dr.

Fig. 4.

Duane, of Schenectedy. It was a very bad case indeed. I operated by the plan of simple denudation over an immense surface; the parts were brought together and healed kindly; but I had not removed tissue enough, and there was a considerable cystocele left, which required that she should use a pessary; and then it was that I devised another method of operating. Instead of the broad scarification of the anterior wall of the vagina, I simply removed the mucous membrane in the form of a V (fig. 5, *a*, *b*), the apex being near the neck of the bladder, the two arms extending up on the sides of the cervix uteri. These two denuded surfaces were brought together by silver sutures passed transversely, thus making a longitudinal fold narrowing the vagina and crowding the cervix backwards. This simple operation was thus repeatedly performed, and always successfully, by Dr. Emmet and

myself, at the Woman's Hospital, from 1858 to 1862, when I left New York.

In Paris I had occasion to perform it for Sir Joseph Olliffe on an old lady sixty-five years of age, who had had procidentia for twenty years. The parts united; the uterus was held in its place, and she returned home in a fortnight.

Fig. 5.

Her general health was very feeble, in consequence of a long residence in India; and in two months the whole cicatrix gradually gave way, and the procidentia was reproduced. This was the first and only case of failure that I had ever seen after this method. The operation was subsequently repeated; but this time, instead of a V-shaped scarification, it was made in the form of a trowel, as represented in fig. 6, the point presenting below, the shoulders above in the anterior cul-de-sac. The denuded surfaces *a c* and *b d* were brought together by transverse silver sutures. A small portion of tissue was left undenuded at *e*, between *c* and *d*, for the purpose of permitting the escape of any secretions naturally forming in the shut pouch *f*.

The mechanical execution of this operation is a matter of some nicety, but it is by no means difficult. Suppose we have such a case as the one represented in fig. 7, which may be taken as a type of its class; we wish to narrow the vagina to keep the parts in their normal relations. We would suppose, *à priori*, that the operation could be done more easily and exactly with the uterus thus protruded; but it is a great mistake. The uterus must first be restored to its proper position, and if the os tincæ is ulcerated as, here represented, or if

Fig. 6.

the vagina is dry, scaly, and skin-like, it will be well to apply glycerine on a tampon of cotton, for a few days, till the ulcerations are healed and the vagina assumes more of a normal appearance; after which the operation may be performed. For this purpose the patient is to be placed on the left side, with my speculum introduced to pull back the perineum and posterior wall of the vagina. We can then get an accurate idea of the dimensions of the over-distended vagina, and with a small tenaculum hooked into the mucous membrane on

each side of the middle line of the anterior wall we can approximate these surfaces, and thus determine whether we should make the denudation of tissue to a greater or less extent on either side. There was at first some little trouble in making the two arms of the V equilateral; sometimes one would diverge a little more from the median line on one side than the other; but this was overcome by using a malleable uterine sound curved as represented in fig. 8. Its convexity rests centrally along the middle line of the anterior wall the distal end pushes back the cervix uteri, while the counter-curvature lies in contact with the urethra. By thus pushing the neck of the uterus back in a straight line, while the anterior wall is depressed centrally, the curvature

Fig. 7.

of the sound is hidden from view by the lateral folds of the vagina, which fall over it and meet in the middle line, showing us exactly where the tissue is to be removed for the purpose of uniting the parts that thus so naturally and easily come together. With the parts thus held, it is very easy to denude

two surfaces a third of an inch wide or more, extending seemingly almost in parallel lines from the neck of the bladder up on each side of the cervix uteri. To make the transverse lines of denudation at the upper ends of these two arms of the V, we remove the curved sound and pull the cervix downwards with a small tenaculum. We must be careful not to make the arms of the V too divergent, and at the same time we must avoid running them too closely together. They should, when united by sutures, relieve the cystocele without putting the parts too much on the stretch. The sutures are, of course, to be passed transversely, beginning below, as represented in fig. 4. The sound is to be retained, pushing the uterus backwards till we come to pass those near the cervix uteri. These should be made to embrace all the denuded tissue, *c*, *d*, fig. 6, excluding the undenuded portion *e*. I think it very important to leave a drain here, as before said, for the discharge of the normal secretions of the pouch *f*.

Fig. 8 represents the speculum in position, and the curved

Fig. 8.

sound pushing back the cervix and depressing the anterior wall of the vagina.

Sometimes, as in cases complicated with rectocele, it is necessary to narrow the posterior wall of the vagina, as well as the anterior. If so, I prefer to make two operations, allowing a period of six or eight weeks to intervene between them.

It is not my intention to draw a parallel between this and the perineal operation for procidentia. I only wish to add another resource to our means of permanent cure in this distressing affection. So far, then, as mere surgical resources rae concerned, we have three processes from which to choose; always, of course, adapting this choice to the peculiar exigences of the case.

1st. Amputation of the cervix, as recommended by Huguier, when its infra-vaginal portion is too long. I have often seen procidentia cured by this alone.

2nd. The perineal operation, as performed by Mr. Baker Brown, Dr. Savage, and others; and

3rd. The operation of narrowing the vagina by the trowel- or triangular-shaped denudation on its anterior wall, as herein illustrated.

Mr. Nunn stated that he had, on several occasions, operated for prolapsus uteri after the plan recommended by Mr. Baker Brown. In most of the cases a partial rupture of the perinæum had existed. In them the result of the operation was satisfactory on the whole; but he considered it very advisable to provide the patient with a suitable bandage, so as to help the new perinæum as much as possible, since there was, undoubtedly, a tendency to expansion. Mr. Nunn adduced one example in which a small aperture was left between the new perinæum and the sphincter ani, that had, after a year or two, dilated to the size of a florin. Where no rupture of the perinæum existed, as in younger women, who had never borne children, Mr. Brown's operation had failed. Mr. Nunn stated that he had operated on patients even of nearly seventy years of age with advantage. He also stated that he had himself, and had also seen Mr. Brown on many occasions, practised a proceeding *somewhat* resembling that described by Dr. Sims, namely, the removal of a V-shaped portion of the mucous membrane of the vagina reaching from the fourchette to within an inch or so of the cervix—the difference being that this removal was made from the posterior instead of the anterior or vesical wall of the vagina.

Mr. Spencer Wells said that the operation suggested by Dr. Marshall Hall had been performed many years ago in London. He (Mr. Wells) had seen two ladies upon whom it had been performed by the late Dr. Hemming, of Kentish Town. In one, circular strips of mucous membrane had been removed all round

the vagina by the knife, in the other by the cautery. No sutures had been used, the idea being to obtain contracted cicatrices. This was obtained, and the uterus was well kept up. One lady had not had children since, and was well content; but the other became pregnant, and was attended by Dr. Rigby. During the labour the head of the child carried the cicatricial rings before it, and literally stripped the vagina of all its mucous membrane. It did not open either bladder or rectum, but the recovery was very protracted. Mr. Wells wished to know whether any such result had been observed in patients who had borne children after submitting to the operation described by Dr. Sims.

Dr. Rasch referred to a number of cases in which he had operated for prolapse or procidentia of the womb. In all his cases there was rupture of the perinæum present, and in all he adopted Mr. Baker Brown's operation, only in two slighter cases omitting the quill sutures. All did well. A very bad case of complete procidentia of many years' standing was much benefited by the operation, and continued so two years after, the os uteri, however, resting on the new perinæum, though not protruding. Dr. Rasch certainly would follow Dr. Sims' very ingenious suggestions, especially where there is no rupture of the perinæum, as in all cases he had operated upon the protruding anterior wall of the vagina was much less relieved than the posterior.

Mr. I. B. Brown, jun., said that the cases of prolapsus uteri on which Dr. Rasch had operated were caused by the rupture of the perinæum, and it seemed but rational, when this was the cause of the prolapsus, to perform the so-called "perineal operation." It was, however, undoubtedly true that, in what might be termed idiopathic prolapsus, cystocele was a very prominent accompaniment, and in such instances he could not conceive anything better than the ingenious operation of Dr. Marion Sims. He would, however, remind Dr. Sims that Mr. Baker Brown, recognising this fact, did, in cases where cystocele was present, diminish the vaginal wall of the bladder, not to the same extent, but in a manner very similar to that of Dr. Sims, namely, by paring the mucous membrane, and bringing the raw edges together by silver sutures.

Dr. Aveling ventured to suggest to Dr. J. Marion Sims whether it would not be advantageous to have the opening for allowing the secretions to escape from the pouch at the lower angle of the triangular space operated on. This would be a more dependent position for the outlet. There would also be another advantage in having it so placed. The mucous membrane immediately over the urethra would remain undisturbed, and there would be no danger when passing the sutures in wounding or closing that canal.

Dr. Wynn Williams remarked that, as regards the success of

the operation performed by Mr. Baker Brown, he had met with several cases that had been operated upon by Mr. Brown, and he must say that the patients appeared to him to have been but little benefited by the operation. Indeed, in one case, where the woman afterwards became pregnant, almost all traces of the operation had disappeared. He had long been of opinion that when the anterior portion of the mucous membrane of the vagina protrudes, which, as the author of the paper states, is usually the case, the tension should be brought to bear on the upper part of the vaginal mucous membrane, and this, he believed, was best attained, in ordinary cases, by wearing a pessary like the one he held in his hand, which acts by making tense the mucous membrane reflected from the vagina to the uterus, the uterus being suspended between the blades of the pessary. Dr. Williams could not remember who was the inventor, but it was improved by the late Dr. James Reid. It is not Zwanck's, having been invented long before his. It has no hinge, but is kept open by its own spring.

Dr. Wilkins, of William's Town, Australia, stated that he had operated on two cases of procidentia uteri, following closely the method of Mr. Baker Brown as described in his book; permanent success had followed the operation, even though one of the cases had been of twelve years' standing. Dr. Tracey, of Melbourne, had also operated on several cases, and he believed with similar results.

Mr. Chambers said he felt that the Fellows of the Society were much indebted to Dr. Sims for his valuable contribution to female surgery; but he submitted that even this operation was inadequate to meet the requirements of all the cases of complete prolapsus uteri which come under the notice of the surgeon from time to time. Thus, this, which may now be called the anterior operation, only takes rank with that which may properly be called the posterior operation, or Mr. Baker Brown's. Mr. Brown has never asserted that his operation is successful in every case of prolapsus uteri. On the contrary, he has for years past combined the two operations in cases necessitating such a procedure, though he (Mr. Chambers) was bound to say that the anterior operation, as performed by Mr. Brown, was a very simple one when compared with Dr. Sims'. He had had two very bad cases of this kind under his care within the last twelve months. One case was of three years' standing. This lady had not been able to leave her house for more than two years. He performed Mr. Brown's operation in November, 1864, and the patient is now in excellent health, having had no signs of a relapse. The other case was that of a poor woman who had suffered from a complete form of the disease for "over two years." Mr. Brown's operation was performed in this case, and for six months she has discharged the duties of her station with perfect ease and comfort. This patient came to the out-

patients' room a month ago, and the parts appeared as perfect as when the operation was first performed. There are two important reasons why the posterior operation so often fails in the hands of some operators—first, the operation itself is *in many cases* very imperfectly performed; and second, the patient is permitted to get up and walk about long before the united surfaces have had time to become perfectly consolidated, or the enlarged uterus to become reduced to anything like its normal size and weight. Cases of this kind ought not to be permitted to leave their bed for eight or ten weeks at least, if the cure is to be permanent.

The PRESIDENT said he had asked for the experience of Fellows on the result of Mr. B. Brown's perineal operation, because, if this were found to fail, the argument in favour of Dr. Sims' operation was much strengthened. He had himself performed Mr. Brown's operation several times. He had found prolapsus return in spite of the provision of a good perinæum. Further, he had known complete prolapsus take place in virgins; in one case especially, that of a girl aged sixteen, prolapsus was caused by epileptic fits, the vulva and perinæum being quite normal. Again, he had repeatedly seen the uterus remain *in situ* notwithstanding large perineal laceration. It was clear to him, therefore, that defective perinæum was not the cause of prolapse, and that operations for restoring the perinæum or contracting the vagina posteriorly could not be expected to cure it. It seemed to him that Mr. Brown's operation was performed in the wrong place. It had no effect in providing support where it was wanted, namely, anteriorly, at the connection of the cervix uteri with the base of the bladder. This object seemed to be perfectly accomplished by the admirably reasoned-out and ingenious operation of Dr. Sims. Dr. Barnes briefly described his view of the etiology of the hypertrophic elongation of the cervix. It began with congestion, inflammation, and partial eversion of the lower margin of the cervix. The outer or vaginal surface of the vaginal portion was the more fixed, whilst the inner aspect of the canal more easily bulged outwards. Then the products of congestion became organized in the tissues, the fluid elements being absorbed. This process continually going on—eversion or growing out of the rugæ of the cervical canal—extension and hypertrophy went on. A demonstration of this kind was obtained by passing the uterine sound up to the fundus, and then gently pressing upwards, so as to push the prolapsed uterus back towards the vagina. The last-formed everted portion of the canal then disappeared under a process of reinversion. This showed how the abnormity might be prevented if the original inflammation were cured in the early stage, and if the uterus were properly supported in its normal position.

Dr. SIMS, in reply to Dr. Aveling, said he left the undenuded portion of mucous membrane near the cervix uteri, because this

was the most dependent part when the patient was lying down. In reply to other speakers, he said that no one method of operating could be applicable under all circumstances to all cases. If there was a lacerated perinæum it was proper to restore it. If there was elongation of the infra-vaginal portion of the cervix, then the proper operation was amputation of the cervix, and this would probably be all that was necessary in such cases. His friend Dr. Eastlake had shown him a case of procidentia two or three days' ago, where it depended entirely upon hypertrophic elongation of the lower segment of the cervix, which projected at least two inches below the insertion of the vagina. This patient had been the rounds of many of the hospitals in London, and nothing had been done for her. The perineal operation and his own method were each equally powerless to remedy such a case. Amputation here was the only resource. He had the pleasure of operating on a patient of Dr. Henry Bennet's, a few months ago, where the procidentia depended upon hypertrophic elongation of the cervix. The operation of amputation alone cured the case. In the majority of cases of procidentia—in all those where a vagino-cystocele formed the first stage of descent—he was satisfied that the operation he had described, viz., that of narrowing the vagina by forming a longitudinal fold of its tissue on the anterior surface, reaching from the neck of the bladder to the neck of the womb, would be one of the safest, simplest, and best. As to mechanical means for such cases, he had seen the instruments fail which Dr. Williams had shown us. He had seen cases in which Hodge's lever, Meigs's ring, globes, discs, and air-balls, were all useless. In some cases Zwanck's pessary would answer; but no instrument could be compared with his simple operation for a radical and permanent cure. Besides this, there were many who could not bear any mechanical apparatus. In old women the vagina was often so delicate and tender that none of the ordinary forms of pessaries could be borne. In such cases, if the patient would not submit to the operation, and could not wear an instrument, there was still one thing left to palliate her condition, and that was she could wear a tampon of cotton, the size of an English walnut. It should be moistened with glycerine, and introduced every morning, to be removed at night. He thanked his friend Mr. Spencer Wells for the information in regard to the operation of Marshall Hall as performed by Dr. Hemming. He was not surprised to hear that cicatricial rings, made around the vagina by the actual cautery, had sloughed away during labour. Marshall Hall's idea of narrowing the vagina was good, but his method of doing it was bad. He gave to Marshall Hall the credit of suggesting it, but claimed for himself that of effecting it properly. To a question, he said his friend Dr. Emmet, of New York, had seen a labour after this operation without injury or accident of any sort.

DECEMBER 6TH, 1865.

Dr. BARNES, President, in the Chair.

Present—48 Fellows, 20 visitors.

The following gentlemen were duly elected Fellows of the Society:—John Brunton, M.D., 207, Caledonian Road; J. Spencer Ferris, L.R.C.P., 62, Great Russell Street, W. C.; D. A. Moxey, M.D., Turnham Green; M. M. Ortez, M.D., Port of Spain, Trinidad; A. E. Sansom, M.D., 29, Duncan Terrace, Islington, N.; H. M. Townsend, L.S.A., Thurlow House, Clapham Rise, S.

Dr. ROUTH exhibited a specimen of fibro-cystic disease of the uterus, from a patient at the Samaritan Hospital. He had made an exploratory incision to remove it, and failed. The diagnosis was made by Dr. Savage, Mr. Fergusson, Dr. Greenhalgh, and himself, and the operation advised by all but Dr. Greenhalgh. Constant sickness, due, doubtless, to chloroform, continued with little intermission for thirty-six hours. Death was due to hæmorrhage from rupture of vessels within the cysts. The highly vascular character of the growth was shown. Mr. Brown's actual cautery had been used on portions of the mesentery with perfect success.

The pathological character of the growth and the impossibility of diagnosis were so important in this case that he would make it the subject of a paper to be read before the Society at some future time. He was only now anxious to show the recent specimen.

Dr. J. BRAXTON HICKS exhibited a polypus weighing two and a quarter pounds, removed by Dr. Oldham, by the

wire-rope écraseur. Before removal it reached from the vulva to just beneath the umbilicus. The patient was doing well.

Dr. Ritchie showed to the society a dermoid cyst developed in the Fallopian tube. He said that the specimen seemed to throw a good deal of light upon ovarian pathology. Some time previously it had been suggested that some ovarian tumours result, not so much from disease of the ovary, as from intra-ovarian development of an ovum; that, in point of fact, some ovarian tumours are analogous to the different forms of moles which are met with in the uterus. It had been objected to this theory, that if it were true then we should expect occasionally to find dermoid cysts in the uterus, similar to those which are developed in the ovary.

Dr. Ritchie said that he had succeeded in finding many recorded cases of intra-uterine dermoid cysts, but that they had almost invariably been explained away as cases where an ovarian tumour had ulcerated through the uterine walls and thus come to lie in the uterine cavity. He had never been so fortunate as to meet with an intra-uterine dermoid cyst, but he now showed to the Society a dermoid cyst developed in the Fallopian tube. The cyst was about as large as a plum. It contained four loculi, which were originally filled with a creamy fluid. Each loculus was lined with a serous-looking membrane, studded at intervals with projecting dendritic growths absolutely similar to those so frequently met with in ovarian cysts. Besides this the tumour contained a plate of true bone one and a half inches long by about half an inch broad. Probes passed through the Fallopian tube from its uterine and fimbriated extremities did not actually enter the cavity of the cyst, but impinged against its outside envelope. The connection between the cyst and the dilated Fallopian tube was extremely close, so as to render artificial separation impossible. The specimen had formed part of the Fallopian tube of a lady upon whom Mr. Spencer Wells had performed ovariotomy. Both ovaries were extensively diseased, and, as Dr.

Ritchie had had an opportunity of examining them carefully, he felt convinced that the tumour which he showed to the Society had at no time formed part of either of them.

Dr. GREENHALGH exhibited a growth which he had recently removed from the cervix uteri.

The patient first applied to him about three weeks before the operation, for what she supposed to be "falling of the womb." On examination, a swelling about the size of a large walnut was detected protruding about an inch from the orifice of the vagina, and arising from the posterior margin of the os uteri. As she was about four and a half months advanced in her fifth pregnancy, Dr. Greenhalgh considered it unwise to attempt the removal of the growth; which, however, in a fortnight increased to about the size of an ordinary orange, causing protrusion of the cervix uteri, and producing such local irritation as to induce him to alter his determination. As the tumour was somewhat pedunculated and extremely vascular, Dr. Greenhalgh considered that excision would be hazardous, and the application of the ligature too irritating; he, therefore, applied a clamp on the upper part of the growth close to the os uteri, by which he was enabled to exert considerable pressure for some minutes; after which he slowly burnt off the whole mass on the distal side of the clamp. Not a drop of blood was lost. For eighty hours the patient continued perfectly well, without the slightest pain, when labour set in, which, in spite of every means to arrest its progress, was followed in sixteen hours by the expulsion of the fœtus in its membranes. The drawings on the next page, for which he is indebted to Mr. Baker Brown, Jun., well represent the appearance of the tumour and parts, just before and immediately after the operation. In fig. 2 the black line represents the charred edge of the pedicle flattened out by the clamp.

A careful microscopic examination of the tumour clearly proved it to be simple hypertrophy of the lip of the uterus.

Dr. GREENHALGH remarked that, although the part must have been considerably stretched during the dilatation of

the os uteri, yet there was not the slightest indication of hæmorrhage.

Fig. 1.

Fig. 2.

Dr. Greenhalgh also exhibited a large fibrous polypus, measuring six and a half inches in length, eleven and a half inches in circumference, and six inches round the pedicle, which he had removed the previous day by Weiss's wire écraseur. The patient, æt. 38, mother of several children, had suffered severely, for two and a half years, from menorrhagia and mettorrhagia which had greatly reduced her powers, and for which symptoms she had been, off and on, under the treatment of an eminent accoucheur. About a week ago, after taking some ergot, the polypus was expelled from the uterus into the vagina, which it completely blocked up and occasioned retention of urine, requiring the frequent use of the catheter. The operation, which occupied only six minutes, was greatly facilitated by the administration of chloroform and ether.

ON AN ABNORMAL VARIETY OF THE BATTLEDORE PLACENTA.

By R. Uvedale West, M.D., F.R.C.S., Edin.

The most frequent form of the so-called battledore placenta is that in which the funis is simply inserted in the extreme edge of that organ. It occasionally happens, however, that the funis is inserted in the membranes at some distance from the placental mass. It then divides into a number of branches—into its separate vessels, in fact, which, diverging more or less, course along the membranes until they reach the margin of the placenta. Of a case attended by myself on May 24th, 1857, I have the following note, accompanied by the sketch (Pl. VI, fig. 1):—"The funis divided into its vessels about four inches from the edge of the placenta, being itself inserted in the membranes before that division." It is obvious that if, in the act of extracting the placenta, traction were made at the funis in such a case, the latter would easily be torn off, the vessels tearing off one after another in consequence of the difference in their length. Such an accident, however, would be of but little consequence, unless it occurred in coincidence with certain other anomalous conditions, such as I will now point out. On the 22nd of June, 1854, I had a case of twins, of which I have the following note and sketch (Pl. VI, fig. 2):—"The second child presented the head near the pubes, and both feet behind it near the sacrum. I brought down the feet, turning the child. The placentæ were united, but one of them was curious in this respect—that its funis was inserted into that portion of its membranes which was in apposition to the membranes belonging to the other placenta, and at the distance of seven inches from the raphè uniting the double organ; it then divided into four or five branches, which coursed along the membranes, widely diverging until they reached the surface of their placenta at the raphè uniting the two; the outermost branches being more than six inches apart on reaching the mass. On the edge

of the placenta there was a deep indentation or notch, across which one of the veins passed, adhering again to the membrane which occupied the space thus made, and then distributing itself on the placental surface again. One of the arteries was torn from its placental attachment, I think during the delivery of the second child, for it was probably the placenta of the first that presented the peculiarities described. The funis of the other child was inserted normally into the centre of its placenta." Being at the time in occasional correspondence with Dr. Ramsbotham, I sent him the placenta, as a present. In acknowledging the receipt of it, Dr. Ramsbotham remarked—"It is certainly a curiosity, and I have given directions at the hospital that it should be preserved. I have seen many in which the vessels of the funis split before entering the mass, but never one in which the division was at such a distance from it. It appears to me incredible how the two small arteries could have supplied the two large veins."

As described in my note, this double placenta was found to have sustained a laceration of one of the abnormally arranged vessels, probably during the delivery of the second child, which was extracted by the feet. It was certainly not caused by traction at the funis, as such traction would have most likely torn all the vessels across one after another. So far, then, no lesson of any practical importance was deducible from this curious deviation from the normal connection between the funis and placenta. It was, however, my impression at the time, vaguely felt, that embarrassment or difficulty of some kind might be caused by such an easily lacerable connection between them; but I could scarcely imagine of what nature. But on the 9th of November, 1863, I met with a case of twins in which this anomaly led to an absurdly puzzling state of things. It was a hasty premature labour, about an eight months' case, and as it occurred in the night at a distance of five miles from my residence, both children were born before my arrival. As I entered the lying-in-room, the nurse announced with great triumph that a second child was just born. Both children were living. I tied

and divided the funis of the second child, and it was removed. After waiting about ten minutes for a pain, I felt under the bed-clothes for the funes, but, sliding my hand along them that I might reach the placenta, I found that one of them was lying loose in the bed, having been torn away by the nurse. I, however, by tracing the other funis to its insertion, found that the placental mass was in the vagina. I drew it away carefully. It was very large, large enough for both children; but, on a hasty examination, I could not, on the supposition that the placentæ were separate, as is often the case, satisfy myself that both had been removed; neither could I, on the other supposition that the placentæ were united, as most frequently happens, ascertain by the presence of the stump of the torn-away funis that I had removed a double placenta. And as there was no raphè or remains of membranes across the centre to show where the two placentæ were united, I was still further at a loss to satisfy myself. I examined again *per vaginam*. All was right there; but the second placenta might still be in the uterus, the mouth of which was closed. What to do then? If I had been quite certain that that placenta was retained *in utero* by incarceration, I might, after waiting a reasonable time, have forced my hand through the os for the purpose of extraction. But such a proceeding would have been quite unjustifiable in the case of an empty uterus. *Au reste*, I could feel through the abdominal parietes the *fundus uteri* small, hard, and well contracted.

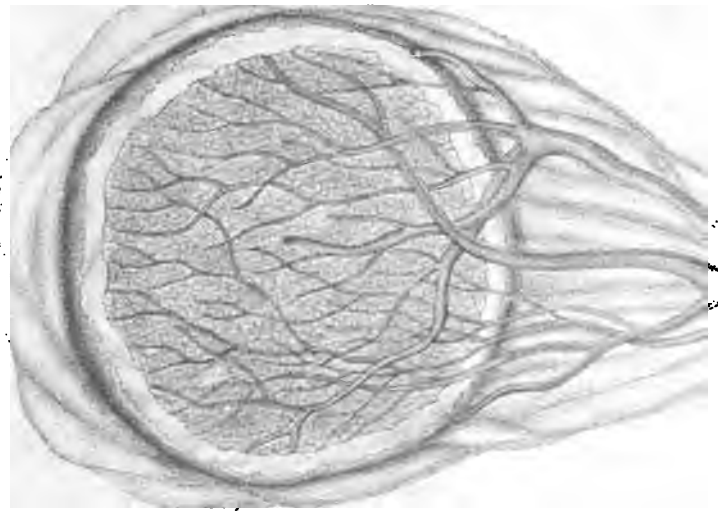
An examination now of the lacerated funis explained the whole matter. A strip of membrane, several inches in length, constituted its torn extremity. I felt, therefore, but little doubt now, that after the birth of the first child the nurse had made traction at its funis for the purpose of extracting the placenta, not suspecting a twin case, and that the funis, having been inserted in the membranes, had been torn away; or, that the second child, in passing through the pelvis, had dragged away the lacerable funis of the first along with it.

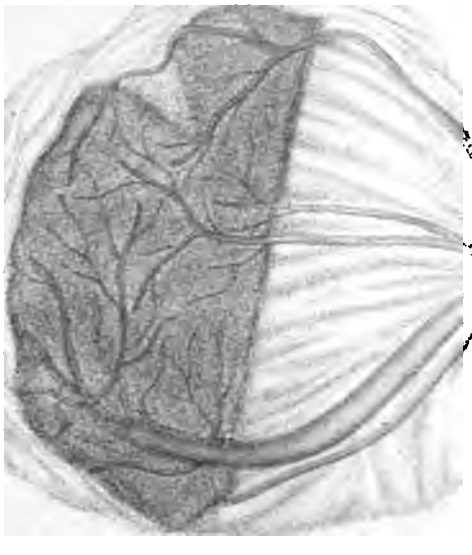
Now, as the placenta was a single one, common to

both fœtuses, there could have been only one bag of membranes, an anomaly of great rarity—which I had only distinctly met with twice before—in one case the twins being united *à la* Siamese, with but one funis; in the other the two funes being implanted side by side, and about an inch apart, near the centre of the placenta. In the former of those cases, as there was but one funis, and the fœtuses were monstrously adherent, there *could* have been only one bag of membranes; besides which, I had found during the delivery, as, indeed, I did in the latter case also, that there was but one bag of membranes to be ruptured. In the present case, on the supposition of a single bag of membranes, the funis which was torn away must have been inserted, battledore fashion, at the margin of the placenta, as in Pl. VI, fig. 1. That of the second child I found normally implanted in the centre.

Well, then, as the peculiarity of a single bag of membranes in a twin case is so rare, I regret, on that account, as well for the reason of doubt as to my patient's safety that was left on my mind by the other circumstances of the case, that I was not present at the delivery of both children, that I might have had, in addition to the appearances presented by the single placenta (viz., the absence of the central raphè with its adhering membranes), the evidence furnished by the touch, of the absence of a second bag of membranes. I need scarcely add that the testimony of an ignorant monthly nurse on this point would have been as valueless and dubious as was her statement that she had not made traction at the funis of the first child immediately after its birth.

I lay the case before the Society as an example of a combination of rare circumstances which may puzzle the accoucheur and cause him some uneasy feelings as to the propriety or safety of leaving his patient. In this case little or no hæmorrhage followed the labour, and all went on right. Neither, as both children were living and lively, was there any evidence, as has been alleged by some writers on the subject, that the child remaining *in utero* is liable to





bleed to death through the placenta, if the funis of the first child be torn away from a placenta common to both.

In the case of the double placenta figured in Pl. VI, fig. 2, such doubts as I have described could not have been felt, even if the laterally attached funis had been torn away, for the obvious reason that the raphè was distinctly present.

TWO CASES OF OBSTRUCTED LABOUR, WITH REMARKS.

By Professor Berry, Birmingham.

Obstructed labour is one of the most important subjects that can engage the attention of the practitioner of midwifery. In natural labour the accoucheur has little else to do than to watch the patient and to receive the child; but when the process is obstructed by any fixed obstacle difficulty soon manifests itself, and a series of important symptoms arise, requiring the utmost skill and the most profound wisdom on the part of the medical attendant to secure the safety of the patient, and, unlike either medicine or surgery, a double responsibility rests upon him, and it often occurs that the safety of both lives is incompatible. "Under such trying circumstances he will have great cause for congratulation if, by his most judicious efforts, he be always able to preserve the most valuable life of the mother, for I do not think there is a more difficult point in the whole range of medical or surgical practice, or an occasion which demands more mature deliberation, more precise knowledge, or a clearer judgment, than are required to enable the accoucheur to determine in cases of difficult labour how long he may trust to nature without compromising the life of the mother, or entailing upon her an existence of misery worse than death itself; or, on the other

hand, to fix the precise time when he is imperatively called upon to sacrifice the life of the child for that of the mother."

Labour is obstructed when the normal relation between the child and the maternal pelvis is interfered with, and this interference may occur in the maternal pelvis alone or in the child alone. But it is not with the child I have so much to do with to-night as with obstructions which occur on the part of the mother, and I cannot refrain from mentioning an interesting case in which I was consulted by a brother practitioner, on account of its novelty, certainly to myself. A lady, the mother of several children, was in labour with a breech presentation; the membranes had ruptured, the feet were in the vagina, and the breech had fully entered the brim of the pelvis; the pains were strong, but no advance was made; traction by the feet produced no effect, and after some time I was requested to see the patient. I found the breech occupying the brim of the pelvis and filling up every part of it, but in passing my finger above the brim and pressing on the part above I thought I felt the abdomen of the child large and soft and supposed this condition to be the cause of the detention; the funis was felt just above the brim and without pulsation. I advised the abdomen of the child to be punctured with the perforator, and immediately there flowed a large quantity of limpid fluid; the delivery was at once effected by traction with the feet. But the most interesting feature in the case was found on dissection of the infant; the abdomen of the child was occupied by a large cyst, and at the inferior portion of the cyst there was a small tubular communication with the fundus of the bladder, thus showing that the cause of difficulty was a pathological condition of the allantois, which should have disappeared within the first few weeks of intra-uterine life, but, from some error of development, continued to increase and maintain its communication with the bladder. This was sufficiently rare to me to deserve being recorded.

Obstructed labour frequently arises from mechanical impediment in the pelvis to [illegible] of the child; the

principal of these are tumours situated within it; these tumours may be osseous, fibrous, fluid, or malignant. The osseous tumours will present greater or less difficulty, according to their greater or smaller size; when large, they fill up the hollow of the sacrum and so encroach on the cavity of the pelvis as to leave no room but for instrumental interference. I much more dread the smaller exostoses which are occasionally found at the brim and sides of the pelvis, and which are frequently acuminated, and if not cared for soon rub through the parietes of the vagina and uterus during its action, and thus give rise to rupture of the vagina and uterus, of which I have seen more than one example. Neither do I wish to speak to you to-night of fibrous tumours which hang down from the sides of the uterus, filling up the brim of the pelvis, but which are occasionally drawn up by the action of the uterus and allow the child to be expelled by the natural efforts, or, if stationary, require severe and dangerous operations for the delivery of the child; but I wish to detail to you two cases of obstructed labour associated with comparatively rare complications, one arising from the presence of a dropsical ovary, and the other from a malignant tumour in the pelvis.

Mrs. —, the mother of several children, and whose labours had all been natural, complained in her tenth pregnancy of what she called lumbago, and took various domestic remedies for it without effect; and as she thought the disease was kept up by her state, hoped that after her delivery she should be free from it, and thus went her full time without directing her medical man's attention much to it. As soon as labour commenced she summoned her medical attendant, who visited her, and on examination found the os uteri high up in the pelvis and dilated to the size of half-a-crown. But was surprised to find the pelvis partially blocked up by a tumour occupying the hollow of the sacrum and encroaching considerably into the cavity of the pelvis. He saw the patient first at night, and, as there was nothing in the case requiring immediate interference, he left her with directions that if the pains became severe to send for him immedi-

ately. He did not see her again till the following morning, when he found that she had been suffering pain the whole of the night, but not severely; the membranes had ruptured, the os uteri was partially dilated, and the head of the child began to press upon the tumour with each pain and render it very tense; the space between the tumour and the pubic bones did not exceed two and a half inches. He determined to wait till the os uteri was fully dilated, as there were no symptoms which appeared to justify him in interfering, and he thought the uterus might squeeze the head through the pelvis. He saw the patient again at mid-day, when the os uteri was fully dilated and the head pressed strongly on the tumour, and, having given the uterus sufficient time to overcome the obstruction and failed, he determined to apply the forceps; these were applied with difficulty, and the head firmly grasped by them; traction was used at first without effect, but after considerable time and force used with the instruments, and an assistant at the same time attempting to push the tumour upwards whilst the medical attendant used traction downwards, together they succeeded in delivering the woman of a dead male child; the placenta came away naturally, and the woman did not appear much affected by her protracted suffering, nor did the medical men see any cause for anxiety. She appeared to go on well till the middle of the night, when she was suddenly taken with a violent fit of coughing, and immediately she felt something protrude from the vagina. In her fright she sent for her medical attendant, who on examining her person discovered a large tumour the size of a fœtal head hanging from the vulva, with its pedicle within the vagina. He was puzzled at the sight, and thought there must have been something left in the uterus after delivery, which had now escaped from its hiding. I was sent for early the same morning, and went by the next train, which was several miles from my residence. On meeting the medical attendant at the house of the patient I found her in an exhausted state, with a very weak pulse, and suffering from constant sickness; upon examination the tumour was out of the vagina, lying on the bed-clothes; the

pedicle could easily be seen passing into the vagina, and upon tracing it with the finger I found it became narrower, passed beyond the uterus, and led to a transverse rent in the vagina, at its upper and posterior part, and then turned directly forwards to the left side of the pelvis in the direction of the lateral ligament; there was no tumour to be found in the pelvis, which appeared of normal size. I told the medical man, after this examination, that I was of opinion that in using the forceps the vagina was lacerated, and during the fit of coughing the tumour was pressed through the rent in the vagina and escaped externally, and this was confirmed by there being no tumour within the pelvis. As she had not made water for some hours, the catheter was introduced and about a pint of water was drawn off. In consequence of her exhausted state it was considered not prudent to interfere with the tumour until reaction took place; we ordered her a grain of opium every four hours, light nourishment, and weak brandy and water, as she required it. When seen the next day the opium had agreed with her and diminished the sickness, but the abdomen was swollen and slightly tender when pressed upon, and on moving from side to side; the pulse was 90 and compressible.

I did not see her again till the day following, when I found the tumour beginning to change colour, but her general symptoms were manifestly improved, and slight reaction had taken place. There was no great tenderness of the abdomen. The lochia were scanty; the bowels had acted naturally, and she had passed water. The pulse continued at 90 and soft. We determined now to remove the tumour. I passed Gooch's polypus canula, armed with a ligature, and embraced the pedicle within an inch of the rent in the vagina, and, after firmly tightening it, with one stroke of the bistoury I separated the tumour below the ligature. The preparation which I now show you is the whole of the tumour thus removed. She was ordered to continue the opium, with her light nourishment and brandy and water. I did not see her again for some time; but the medical man writes me

word that "on Saturday and Sunday (that is, on the third and fourth days) following the operation, tympanitis to an alarming extent came on, and I was doubtful whether air had not found its way into the peritoneal sac, and had almost made up my mind to pass an elastic tube, but by grain doses of opium and carminative mixtures the tumefaction lessened, and I then gave a pill with calomel, rhubarb, and colocynth, since which the bowels have continued in a relaxed state. The sphincter ani has lost its power, and the evacuations are passed without control. The lochia are scanty, and there is no attempt at secretion of milk." In two or three days he writes again, "I think there is to-day slight improvement in the retentive power of the sphincter ani; the ligature came away just one week after the operation." He again informs me, "the patient is now dressed and lying on the sofa in a state of convalescence." In a month from the time of her confinement she considered herself well, and shortly resumed her domestic duties; in about two months she called upon me at my house in her usual health; in eighteen months she again became pregnant, went her full time, and passed through her labour without any let or hindrance.

This case is very remarkable and instructive. There can be no doubt that the laceration of the vagina was occasioned by the improper use of the forceps and the force used in the extraction of the child. It should ever be borne in mind that the forceps is not an instrument to be wielded with force, and when violence accompanies the use of the instrument, it appears to me, we have chosen the wrong instrument. In all midwifery operations it is not what we can do with this or that instrument, but what we can do safely. Dr. Blundell has observed, "It would be well to have engraved on one of the blades of the forceps the motto 'Arte non vi.'" And well would it have been for many mothers if this motto had always been remembered. In this instance the "ars" was forgotten, but the "vis" was in lively remembrance. The proper course to have pursued in this case was to puncture the tumour and thus diminish its size, and

there was sufficient fluid in it to justify the operation and hold out the hope that the uterine action would then have been equal to overcome the obstruction; or if the uterus failed in its endeavours to overcome the difficulty, then the forceps might have been used to assist the propelling powers under the most favorable circumstances. The case, also, is one of interest that the rupture of the vagina produced so few symptoms, and that her recovery was so rapid after the operation which removed from her a diseased organ, which in process of time would, in all probability, have so increased in size as to have occasioned her death, unless, in the mean time, she had fallen in with one of the ovariotomists of the day, who, I think, would certainly have had to boast of a successful case and a trophy of his skill and dexterity. I am not aware of a similar case to the above, with such a successful result, in the annals of midwifery.

And now I have to speak to you of another cause of obstruction to labour, of a very different nature and with a very different termination. Mrs. —, æt. 39, fell in labour of her thirteenth child, eight still living, and was reported always to have had easy labours. About eighteen months previously felt great pain in the region of the sacrum, which had continued more or less till the present time. She did not seek relief for it, and when she became pregnant thought nothing could be done. She was taken in labour at her full time, and sent for her midwife, who, on examining her, stated she could find no passage. The membranes broke in the night of the day she was taken ill, and a medical man was sent for early in the morning, and, on examination, he found the pelvis occupied by a tumour which prevented the head of the child from entering into the pelvis. I saw her early the same morning, and found a tumour in the posterior part of the pelvis, filling up the hollow of the sacrum, extending upwards to the brim of the pelvis and downwards to the inferior part of the vagina; it projected into the cavity of the pelvis, diminishing the antero-posterior diameter to about an inch and three quarters, or less than two inches; but at the sides of the pelvis there were fully two inches. Obscure fluctuation was thought to

be felt. It was slightly compressible, and supposed to contain a viscid fluid. The finger in the rectum discovered that the tumour was situated behind it and pushed the walls of the bowel before it, and here fluctuation was more distinct. I considered it a cyst containing a viscid fluid arising from the sacrum, and thought that by puncturing it and letting out the fluid the difficulty would be considerably diminished. The woman was in good health and spirits; the os uteri was fully dilated, and the pains were recurring with regularity and force, and driving the head of the child against the tumour, which slightly compressed it and made it tense without allowing any descent of the head. She cheerfully submitted to anything that was recommended for her relief. I thrust an exploring needle into the tumour, and in the groove came away some creamy matter. I then punctured it through the rectum with a curved trocar, and, fancy my dismay, instead of seeing a fluid discharge from the canula, nothing but a stream of florid blood flowed from it, and this continued so long as the canula was retained within it. Although she lost a considerable quantity of blood, there was no sensible diminution of the tumour. I now began to see the serious nature of the case, and considered that the tumour was of a more solid character than I first anticipated, perhaps of a cancerous character; and as there was less than two inches in the antero-posterior diameter, and only a little more than two inches at the sides of the pelvis, it appeared to me that there was no alternative but the Cæsarean section; but before urging this I requested a medical friend to see the case with me, and have his opinion. After careful examination he thought that, after perforating the head of the child and removing its contents, it would be possible to deliver the woman. The tumour might be so compressed as to allow the child to pass. Not quite agreeing with this opinion, but easily persuaded to turn aside from so serious an operation as the Cæsarean section we determined to perforate the head, which was high up. This was done, and the cranium emptied of its contents; but, after great extractive efforts, we could not effect delivery. The head descended a

little during the extractive efforts, but as soon as traction ceased it receded. There was great difficulty to get the instruments to hold. The craniotomy forceps, crotchet, and cranioclast, were all tried in their turn, and when we thought we had a firm purchase either the instruments slipped or the bones gave way, and thus, by little and little, we removed the whole of the vault of the cranium. Seeing the difficulty we were in, we determined to make an attempt to turn the child. The feet were with difficulty laid hold of and brought down, and when the breech began to enter the brim of the pelvis it required continued and considerable force to cause it to pass the obstruction; this, however, was at last effected. The head, in consequence of its being lessened, created difficulty, but not so great as the breech. The termination appeared to justify the opinion of my friend, and gave him a temporary triumph. The woman was now in an exhausted state, and required the free use of brandy; the womb continued large and showed no disposition to contract; there was not much hæmorrhage; the placenta was still within the uterus. Stimulants were freely given, and friction over the uterine region produced no effect; she became weaker and weaker, the pulse could no longer be felt at the wrist, and in an hour after delivery she died, the uterus remaining large and flaccid, and the placenta within it.

The body was examined twenty-four hours after death. On laying open the abdominal parietes the uterus was seen as high as the umbilicus of the patient, and on raising it up and turning it to one side we discovered about a pound and a half of blood in the cavity of the pelvis, and on removing this there was a laceration of the vagina and uterus to the extent of two inches. On cutting into the uterus the placenta was only partially detached, two thirds adhering to the fundus uteri. On removing the uterus and rectum we came upon the tumour, which was much reduced in size, and resembled the brain in structure, was very vascular, and sprang from the bones of the sacrum—an instance of medullary cancer of the sacrum. Although from the nature of the disease there was no hope of recovery, yet I must confess we

committed a grievous error in our mode of delivery. By it two lives were probably lost; whereas, if the Cæsarean section had been performed, I believe we should have given the woman a better chance of recovery, and possibly have saved the life of the child.

Such are the two cases which I have just detailed to you. The first, with its complications and successful result, is worthy of being brought before this Society. The latter case, or others similar to it, though rare, must have occasionally fallen under the notice of the more experienced members of this learned Society. We learn from it that in the practice of midwifery our treatment of these difficult cases should not rest always on what is possible, but on what can be done safely and for the best interests of both lives.

The discussion on this paper is incorporated with that of the following (*vide page* 286).

ON THE COMPARATIVE MERITS OF THE CÆSAREAN OPERATION AND CRANIOTOMY IN CASES OF *EXTREME* DISTORTION OF THE PELVIS.

By Robert Greenhalgh, M.D.,

PHYSICIAN-ACCOUCHEUR TO ST. BARTHOLOMEW'S HOSPITAL, AND LECTURER ON THE DISEASES OF WOMEN AND CHILDREN; CONSULTING PHYSICIAN TO THE CITY OF LONDON LYING-IN AND SAMARITAN HOSPITALS; ETC., ETC.

The subject which I have the honour of submitting to your consideration this evening, is one of the gravest to which the attention of the accoucheur can be directed, as it involves a most responsible decision and deeply concerns the lives of two fellow-beings during the performance of a most important natural function. I do not exaggerate its importance when I affirm, that the lives of mothers and

children depend, in many of these cases, solely upon the judgment, skill, and timely interference of the practitioner. Moreover, this subject further involves two great principles of British midwifery, one of which has been almost absolutely observed, whereas the other has, to my idea, fostered a system productive of much evil. The first concerns the value of the child's life in certain hazardous cases of craniotomy; the second has reference to that axiom uttered more than fifty years ago, by a distinguished teacher, that "meddlesome midwifery is bad."

In order to avoid any possible misunderstanding, I will define the class of case to which this communication has especial reference.

Permit me to assume a case: a practitioner is requested by a woman, who is either a dwarf, rachitic, or the subject of mollities ossium, when about six or seven months advanced in pregnancy, to attend her in her approaching accouchement. The name, address, and date of the expected confinement, are, in too many instances, the only particulars of which he takes cognisance. The patient, at or about the anticipated period of labour, is taken with periodic pains, for which she sends to her medical attendant, who, on his arrival makes a very cursory vaginal examination, finds the os uteri but little dilated and leaves the house. Perhaps he has, perhaps he has not been able to make out the presentation. Hours elapse, during which the pains become more frequent and severe, the os uteri is now fairly dilated or dilatable, the membranes may or may not have ruptured, the presenting part is still high up, and is probably the head. Many hours—painful and distressing hours to the patient, pass by in fruitless efforts at expulsion, and may be with little or no advance of the presenting part. The practitioner hopes, the patient and friends confide, until either fever or prostration, or a total cessation of the pains arouses suspicion and courts anxious inquiry. At length a consultation is sought with some one more experienced, observant, and thoughtful, when for the first time a careful examination is instituted. At once the finger reaches the promontory of the sacrum

with facility, thereby, proving that considerable contraction exists. With more or less difficulty, according to the position of the presentation or dexterity of the practitioner, a fair estimate of the nature and amount of the deformity is determined, either by the finger, or fingers, or some mechanical appliance. Let me assume that the conjugate, the true conjugate, diameter of the brim measures little more than two inches. Under these circumstances, and possibly with the child alive in utero, one is called upon to deliver the patient, who may have been in labour many hours and even days, and whose genitalia are swollen, hot, and tender, and whose general system and uterus have broken down under protracted suffering. This is no imaginary case, as the experience of many can attest. What is the duty of the general attendant when called upon to attend such a case? Clearly, at once to ascertain the state of the pelvis, whether there be any deformity; and, if so, its character and amount; or, if not equal to the task, to summon the aid of some one, before the patient is exhausted, whose qualifications or experience render him more competent to form an opinion and render the necessary and timely assistance. I will assume, and I feel sure I am correct in the assumption, that no one present would fail to recognise a dwarfed or rachitic conformation of body, or a case of mollities ossium, when so far advanced as to occasion an amount of distortion such as you are called upon to contemplate. His suspicions once aroused he would lose no time in determining the nature of the case and the course to be adopted. I will briefly narrate a case in point.

I was requested by Dr. Hadaway to visit a patient, aged twenty years, the subject of severe rickets in early childhood. She had reached the full period of her first pregnancy when she was taken in labour early in the morning of the 19th of February, 1863. When seen by Dr. Hadaway, about seven o'clock in the morning, the pains were frequent and severe, the membranes ruptured, and the head presenting at the brim of the pelvis. From the history of the case and the ease with which he could reach the promontory of the sacrum with his

finger, he was convinced that the conjugate diameter of the brim measured under two and three quarter inches, and that the pelvis generally was below the average size. Being satisfied that no child of ordinary dimensions could pass unmutilated through so small a space, he sought my advice. After a careful examination I was enabled to confirm his opinion, when, without further delay, I performed craniotomy. As she was young, her powers unimpaired, and the pains frequent and severe, we determined to leave the expulsion of the child to the unaided efforts of nature, at least, for some hours, in preference to having recourse to the more hazardous expedient of attempting immediate extraction by the crotchet. At seven o'clock in the evening Dr. Hadaway again visited his patient, when he found the os uteri fully dilated and the vault of the cranium occupying the sacral cavity, the base of the skull being still above the brim. As the presenting part was now within easy reach, he introduced his fingers into the hole made by the perforator, which enabled him to pull firmly on the head during each pain. In less than an hour he succeeded in delivering the patient of a fully developed child, without injury or risk to the mother. Had she fallen into less experienced hands, the probability is that after many fruitless expulsive efforts on the part of the uterus, prolonged over many hours, general and local symptoms of a grave character may have arisen, when the perforator and crotchet would have failed to have rescued her from an untimely fate.

Permit me briefly to narrate another case. On the 30th of last October, I was sent for to a patient of dwarfed conformation of body, who, I was informed by the gentleman in attendance, had been in labour but a short time when he detected considerable pelvic distortion. Previous to my visit the forceps had been applied, which, slipping, occasioned considerable laceration of the posterior margin of the os uteri and of the external orifice of the vagina. After a careful examination we concluded that the conjugate diameter of the brim was under two and three quarter inches. As the child was alive, and a large portion of the vault of the cranium was

engaged in the brim, the pains being fairly effective, it was deemed expedient to apply the long curved forceps, partly with the view of making an attempt at delivery, and partly to enable me, should perforation be required, to fix the head and use them for the purpose of extraction. After every reasonable endeavour with the forceps, I was compelled to have recourse to the perforator, crotchet, and craniotomy forceps. The extraction of a large child was, after much hard pulling, safely effected in about two hours after the perforation; the long curved forceps holding on to the last, and materially aiding our efforts.

I trust you will pardon me for instancing a case of a very different character. Scarcely more than a year ago I was summoned by a practitioner to the following case:

M. A—, æt. 23, a healthy, vigorous young woman, had suffered during early childhood from rickets, which had left well-marked traces behind. On my arrival I learnt that she had reached the full period of a normal pregnancy, when she was taken in labour; that the pains for the first five hours had been weak and infrequent, that for forty-five hours they had been powerful and rapid "enough to bring four or five children into the world;" but that during the last two hours they had almost entirely ceased, and that the membranes had been ruptured thirty-four hours. Her skin was hot and slightly perspiring; pulse 140 and feeble, notwithstanding the frequent administration of nourishment and stimuli. She complained of great thirst and headache, and the tongue was covered with a thick brownish fur, and the lips and teeth with sordes. She had also vomited recently. The abdomen, much distended, was exquisitely painful, the genitalia hot, swollen, and tender, the os uteri fully dilated. The vault of the cranium, which occupied the brim and upper part of the sacral cavity, the scalp being much swollen, had not "materially advanced" for more than twenty hours. A careful admeasurement of the conjugate diameter of the brim convinced me that there was a space of nearly, if not quite, three inches. As I could not detect the child's heart with

the stethoscope or ear, I determined at once to open the head and terminate the labour by the crotchet, which was effected with due care in about an hour; notwithstanding which she sank, exhausted, in about thirty hours after delivery.

I might add many other cases to those already narrated, but I feel confident that the experience of most of my hearers will supply them with numerous facts illustrative of the possibility of determining, at an early period of labour, not only the existence of great pelvic distortion, but also its amount, as well as the great and too frequently fatal effects arising from procrastination in such cases.

As one of the chief objects of this paper is to place on record another case of Cæsarean section, the second which has recently occurred in my practice, I feel I cannot do better than insert it here.

Mrs. W—, æt. 32, supposed to be subject to "rheumatism of the hips," for which she has recently been under treatment in one of the metropolitan hospitals, states that her first four pregnancies, labours, and recoveries, were perfectly normal; that after her fifth confinement her health began to decline, the chief symptoms being constant gnawing pains about the hips, loins, and upper parts of the thighs, and general debility, which incapacitated her from fulfilling her ordinary domestic duties. Notwithstanding her impaired health she became pregnant for the sixth time, during which pregnancy her symptoms increased; she, however, went the full period and passed through a difficult and protracted labour of thirty-six hours' duration, giving birth to a dead child. Again, for the seventh time, she became pregnant, when her pains and debility became so aggravated as almost constantly to confine her to the bed or chair; she, however, reached the full period and was taken with pains of an irregular and feeble character early in the morning of the 6th of last November, which continued with varying intensity until the evening of the 8th, when they became "frequent and strong." The pains recurred with much regularity and force up to the

morning of the 10th, when the os uteri was fully dilated and the membranes ruptured, but "with no progress in the descent of the fœtus." During the evening of the 10th the two practitioners in attendance sought the advice of Dr. Arthur Farre, who diagnosed extreme distortion of the pelvis due to mollities ossium, with presentation of the nates (right tuber ischii) at the brim. Being urgently required elsewhere at the time, Dr. Farre despatched a messenger to request my attendance, but as I was absent from home he was referred to Dr. Eastlake, who immediately repaired to the patient's house. After hearing a history of the case and making a careful examination, he was fully convinced of the correctness of Dr. Farre's diagnosis, and further that it would be utterly impossible to deliver the patient per vias naturales. At this juncture Dr. Eastlake called upon me, and we at once started in company with Dr. Meadows, amply provided with every instrument and appliance which could be required. I found the patient's skin hot and dry, tongue furred and raspy, pulse 140, and feeble. She complained of great thirst and headache, of an inability to move, and some tenderness over the abdomen, with occasionally slight labour-pains. The vagina was hot, swollen, and tender. After a most careful investigation and anxious consultation, in which not only the amount of deformity, the presentation and position of the fœtus, and the condition of the patient were duly considered and weighed, we unanimously agreed that, bad as would be her chances of recovery after any operation, the Cæsarean section unquestionably afforded the best. As further delay was most undesirable, immediate preparations were made, and I commenced that operation with the assistance of the gentlemen above named and her two medical attendants, at one o'clock in the morning of the 11th of November. The bladder and bowels being emptied, I divided the abdominal parietes in the course of the linea alba to the extent of about seven inches, when I came down upon the uterus, which, although closely enveloping the body of the child, was not contracting. It had a bluish-red appearance, with numerous large vessels standing out in bold relief and coursing over

the surface. While completing the parietal incision I accidentally made a small cut in the upper part of the body of the uterus, which bled freely, but was speedily arrested by the pressure of the finger. I had not to wait long before the uterus acted, when the bleeding ceased. During contraction it became less red and blue, and put on a yellowish red-colour and smooth aspect, which altered appearance was doubtless due to muscular contraction and consequent emptying of its blood-vessels. While the uterus was contracting I divided the anterior wall an inch below the fundus, and in the mesial line, to the extent of about six inches, during which little blood was lost, the edges of the wound immediately retracting. It is worthy of remark that the uterus was so thin that in cutting through its anterior wall I made a slight incision in the back of the fœtus which presented at the wound. Owing to the complete and long escape of the liquor amnii I had some little difficulty in extracting the child, which was of large size and dead. I may here mention that although a very audible bruit had been heard by one of the gentlemen present, who ventured to predict that the placenta was attached to the anterior wall of the uterus, yet it was found adherent to the posterior wall, and to the left side, from which it was easily detached and withdrawn. As the uterus was not firmly contracted, and as there was some tendency to hæmorrhage from its inner surface, some flannels wrung out in cold water were applied, and firm pressure was kept up for some minutes. All fears of further loss of blood having passed, the edges of the abdominal wound were brought together by interrupted sutures, the whole being secured by broad strips of adhesive plaster, pads, cotton-wool, and a broad bandage. Chloroform was administered, from the effects of which the patient quickly recovered after the operation. Brandy and ice, with beef-tea in frequent and small quantities, were ordered, and two grains of opium were administered. An hour after the operation, she vomited slightly; pulse 180, regular; skin warm and moist; free from pain.

November 11th, 4 p.m.—Slight vomiting from time to

time, pulse 136, regular, skin warm and moist, free from pain, has dozed occasionally, is cheerful, countenance not so anxious, complains of some thirst, and expresses a wish for bread and milk which was granted.

12th, 5 p.m.—For the last twenty-four hours has continued to improve, has enjoyed her food, vomiting ceased; pulse 124, regular and less feeble.

13th, 3.30 p.m.—Shortly after my last visit severe vomiting set in, so that she could not retain anything on her stomach, pulse 150, regular and very feeble; cold clammy sweat on forehead, is loosing temperature; hitherto hopeful, she now despairs and says she shall die. Ordered enemas of beef juice, brandy, and laudanum every three hours, and grain doses of opium; hot bottles to the feet.

Notwithstanding every endeavour to save her, she sank exhausted at 9 a.m. of the 14th, eighty hours after the operation.

Post-mortem, thirty hours after death, by Mr. Hemborough. —The abdominal wound, about five inches in length, looked healthy, and had united, with the exception of the lower inch. The abdominal cavity was free from blood, serum, and lymph; the intestines, however, were stained blood red. The uterus was fairly contracted, and lay above the brim of the pelvis; the wound, about four inches in length, was gaping in its centre to the extent of an inch.

There were no other *post-mortem* appearances worthy of note. The pelvis, which I submit to your inspection, was very light and soft, and contained a large amount of fatty matter. It is also remarkable for its depth, closely resembling in that respect the male pelvis. It has the peculiar beak-like projection of the pubes, with contracted arch so frequently observed in pelves affected by mollities ossium.

The dimensions of the pelvis are as follows:

Brim:

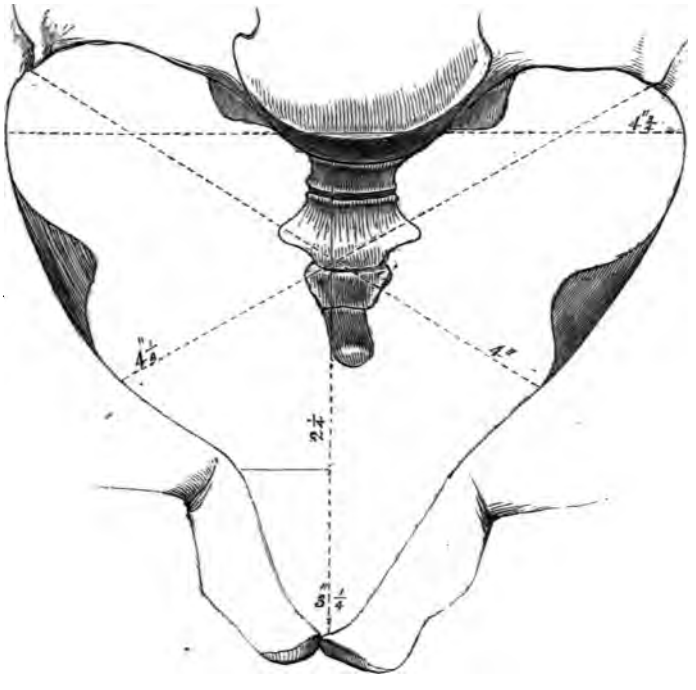
True conjugate	$2\frac{1}{4}$—$3\frac{1}{4}$ in.
Transverse	$4\frac{3}{4}$ inches.
Oblique	4 „

Outlet:

Antero-posterior	2	inches.
Transverse	$2\frac{1}{2}$	„

Depth:

From promontory of sacrum to top of coccyx	$3\frac{1}{4}$	„
From linea pectinea to tuberosity of ischium	4	„
From upper part of pubes to apex of pubic arch	$1\frac{7}{8}$	„



The case just narrated forcibly illustrates the futility of delay. After nearly five days of active labour, sufficient, to use the expression of the females present, "to bring a dozen children into the world," the powers of the uterus were unable to force even the soft and yielding nates into the brim of the distorted pelvis. Moreover, this case proves to demonstration how trifling was the shock of a grave operation, even when performed upon a woman greatly reduced

in general health by a mortal disease, and while in a state of alarming prostration.

I cannot allow this opportunity to pass without concisely relating two interesting and fatal cases of protracted labour due to great pelvic distortion, recorded by Dr. Murphy, in which the perforator and crotchet were used.

In the first case the patient had been in labour fifty-three hours before delivery was accomplished, she sank twenty hours after the operation, The pelvis measured two inches and a quarter in the conjugate diameter of the brim.

In the second case the patient had been seventy-two hours in labour before the extraction of the fœtus, she died in six days. The pelvis measured two inches and one fifth in the conjugate diameter of the brim.

Dr. Robert Lee at page 87, case 35 of his 'Clinical Midwifery,' relates the following deplorable case. Mrs. Jarvis, æt. 36, the subject of gradually increasing mollities ossium for upwards of six years, reached about six months and a half of her fifth pregnancy, when Dr. Lee, after several attempts to puncture the membranes, at last succeeded. The escape of the liquor amnii was followed the next day by labour-pains which continued "strong and regular over a period of six days, when the nates were found to present." He states, "the abdominal and thoracic viscera were then drawn out with the crotchet, and the upper extremities were brought down." The occiput was subsequently perforated and after "strong traction, made for some time," the head was extracted with the "bones all crushed together." Dr. Lee remarks, "after this severe and tedious operation she was left in a very exhausted state, and died the following day, with vomiting and other symptoms of ruptured uterus," which proved to be the case as was revealed on a *post-mortem* examination. The pelvis generally was much distorted "the arch of the pelvis does not exist."

Brim:

Conjugate	$1\frac{3}{4}$ inches.
Oblique on left side . . .	$1\frac{1}{2}$,,
,, right side . .	$1\frac{1}{4}$,,

Outlet:

Conjugate	2 inches and 3 lines.
Transverse	3 or 4 lines.

It is worthy of note, that Dr. R. Lee had attended this patient in all her labours, he, therefore, could not be ignorant of the nature and amount of the distortion. He confesses "I feared that it would be necessary to have recourse to the Cæsarean operation to prevent her from dying undelivered." Would it not have been better and more humane to have allowed this poor creature to complete the full term of pregnancy and then to have performed the Cæsarean section, which under these circumstances would have been far less painful, difficult, and hazardous, and would probably have been the means of saving the lives of both mother and infant.

In the cases hitherto recorded I have endeavoured to show that there was no doubt as to the existence, and but little as to the amount of distortion, and the results which would ensue; still, cases do every now and then occur which deceive the most wary, of which the following may be taken as examples.

Some years ago I was sent for by Drs. Ayling and Chapman to see Mrs. D— who had suffered from severe rickets in early childhood. When taken in labour at the full period of her first pregnancy, her attendants soon discovered that her pelvis was much distorted, and that the head which presented could not enter the brim. Being anxious to give the expulsive process of nature a fair chance, they determined to delay instrumental interference until either her general powers or local condition became affected; when they proposed, if necessary, to avail themselves of my aid. At the period of my visit this patient had been in labour about thirty hours without any advance of the presenting part, and without having materially interfered with her powers. After a careful examination of the pelvis under the influence of chloroform we agreed that there could be little if any more than two inches and a half in the conju-

gate diameter of the brim, besides which the pelvis generally was much below the average dimensions. As much harm might result from further delay I at once proceeded to use the perforator, but the head which rested on the brim was so moveable, that it was found utterly impossible by any amount of abdominal pressure to steady it; I, therefore, applied Naegele's long forceps on either side of the pelvis, with which I obtained a firm grasp on the head. While endeavouring, by forcible traction, to fix the head in the brim, I was not a little surprised to find the presentation advancing. About three quarters of an hour's powerful pulling sufficed to deliver her of a full grown child which had evidently been dead some days. She made a good recovery, became again pregnant, and was delivered about the sixth month, after many hours of severe suffering. Ere long she became pregnant for the third time, and completed her eighth month, when she applied to St. Bartholomew's Hospital for attendance. Premature labour was induced without delay, by my midwifery assistant, who, finding no progress, although the pains were frequent and powerful, attempted to apply the long forceps, but failing, despatched a messenger for my assistance. I found the patient much exhausted, the os uteri fully dilated, the head above the brim and very moveable. All our attempts to steady the head, with a view to perforation, were in vain, and I was ultimately compelled to seize the foot which was within easy reach and draw down the body, and then to introduce the perforator through the occiput, which, after several attempts, I succeeded in accomplishing. Finally I effected the delivery of a large male child with a firmly ossified head, the placenta soon followed. Although this patient lost but little blood, she never rallied and died in thirty-two hours, with symptoms of ruptured uterus. *Post-mortem* by Dr. Andrews twenty-eight hours after death. There was a considerable amount of partly fluid, partly coagulated blood in the cavity of the peritoneum which had escaped from a large rent extending across the upper part of

the vagina, running backwards and upwards to the right side and through the cervix uteri.

The pelvis, which was exhibited, measured as follows:

Brim:	
Conjugate	$2\frac{3}{8}$ inches.
Transverse	$3\frac{3}{4}$ "
Oblique	$4\frac{6}{8}$ "
Outlet:	
Conjugate	$2\frac{7}{8}$ "
Transverse	$3\frac{1}{2}$ "

I have little doubt that the laceration was occasioned by the forcible endeavours to perforate a firmly ossified and moveable head, by which undue pressure was transmitted to the anterior wall and fundus of the uterus. The account of this patient's first labour is interesting as showing the small space through which a dead and decomposing fœtus may be drawn without opening the head.

A still more extraordinary case is recorded by Dr. Simpson, in his 'Obstetric Memoirs,' vol. i, p. 665, in which a putrid child was expelled by the unaided powers of nature through a space of three inches in the conjugate, and one inch in the transverse diameter of the outlet of the pelvis. Still in determining when and what kind of interference is necessary, we must not base our calculations upon such exceptional cases as the three just recorded.

It is obvious from the foregoing cases, and many others which might be added did time permit; that craniotomy and crotchet operations are only safe within certain limits, and under certain conditions, and that cases every now and then occur, in which, although delivery may be effected by the crotchet (Dr. Lee's case), yet so great are the immediate and subsequent risks, that the Cæsarean section, while offering a fair chance to the child, would be attended with no greater, probably less, hazard to the mother. Quite understand me that I do not, under any circumstances, recommend the destruction of the mother for the sake of the child.

Permit me now to direct your attention to the relative mortality resulting from severe crotchet operations and Cæsarean sections. Partly for want of time, partly from a lack of easily accessible and well-recorded materials, I am unable to place before you such a body of statistical facts as the importance of the subject appears to demand. I, however, regret this the less, inasmuch as any amount of statistical data would have little or no practical bearing upon the individual cases we are called upon to treat. Still I will lay before you a brief summary of such cases as have come under my own observation, which I trust will have some weight in determining our future practice.

In all, six cases of extreme distortion of the pelvis in which the conjugate diameter did not exceed 2 inches and a half, requiring the use of the perforator and crotchet have come under my notice. All the patients had reached, or nearly so, the full period of pregnancy. All had suffered more or less generally and locally from the effects of protracted labour, varying from thirty-two to seventy-two hours. In five cases the head presented at the brim, into which it was tightly jammed in three cases; in the sixth the nates presented. The periods occupied in the extraction, varied from three to thirty-two hours. Five of the patients died between two hours and seven days after delivery, either from exhaustion or some inflammatory lesion; in two the vagina and uterus were ruptured; the sixth ultimately recovered, after a severe attack of peritonitis, underwent the Cæsarean section, from the effects of which she died on the fourth day. In two out of the six cases the fœtal heart was distinctly audible just prior to the perforation, and from the appearances of the remaining four children, I have every reason to believe that their deaths were recent, and due to prolonged pressure. Thus out of twelve lives, only one life was saved, and that almost miraculously. Let us contrast these with seven cases of Cæsarean section which have come under my care. Four had reached the full period of pregnancy, one eight months (footling presentation), upon whom craniotomy was per-

formed, prior to the Cæsarean section, one at six months and a half, while a third had reached the sixth month and was operated upon immediately after death from diseased heart. Two were operated upon shortly after the commencement of labour, one died in four days, the other lived three weeks, recovered the operation, and ultimately died of rupture of the colon. Four were operated upon after being much reduced by protracted suffering. Three of the children were born alive, and in the fourth, the fœtal heart could not be detected by the stethoscope just before the operation.

Thus out of ten lives, three (children) were spared.

It has been computed, by Keyser, in his excellent work on the Cæsarean section, that out of 164 cases, 62 women recovered, and 102 were lost. Where the operation was performed after the labour had lasted only twenty-four hours, there were 20 successful and 40 unsuccessful cases. And, taking the same 164 cases, in 158 of which the infant's condition is reported, we find that 57 were stillborn, and 101 survived; and that after a labour of twenty-four hours' duration, 42 were successful, and 16 unsuccessful to the child.

I much doubt whether the more timely application of art, combined with the utmost dexterity in the use of modern appliances, will so materially lessen the mortality as to bring it up to the standard of favorable Cæsarean cases. The means which facilitate craniotomy by bringing the child within easier reach are the very means by which the greatest amount of evil is inflicted on the mother.

After weighing these facts as far as they go, I feel confident that the most sceptical must admit that the mortality to the mother is as great, if not greater, from craniotomy and crotchet operations in *extreme* distortion of the pelvis, as in the Cæsarean section; whereas by the latter, which is a far easier operation, and therefore requiring less dexterity, the child stands a chance of life, which by the former procedure is wholly precluded. Nothing would induce me again, even under the most favorable circumstances, to attempt delivery by the crotchet where the conjugate (true) diameter of the brim does not fully measure two inches,

exclusive of the soft parts. And cases have arisen, and will again arise, where a larger space exists, but where, either from a generally distorted or altered shape of the pelvis, or from great exhaustion, or from inflammation and swelling of the passages, or malposition of the child, and more especially where the child is alive, where I should not hesitate to prefer the Cæsarean section to craniotomy. "It ought not to be forgotten," says Burns, "that it is one thing to extract and another to extract safely in extreme deformity. It is possible after much exertion to bring away the child; but every one must have seen the mother lost in cases where the capacity of the pelvis was far from being reduced to a minimum. We ought to be satisfied, not only that we can bring through the child, but that we can do so, without so much violence as must in all probability kill the mother." He concludes, "I question much, if extreme cases be not as dangerous to the patient as the Cæsarean operation; certainly they are more painful."

It may be asked, how are we to secure these favorable conditions for success? By avoiding the routine midwifery alluded to in the earlier part of this communication, and by making a special study of each individual case as soon as it presents itself. And further, I must strongly protest against the too rigid observance of that oft-repeated axiom, that "meddlesome midwifery is bad," which, however good in days gone by, when the practitioner was comparatively ill-informed, and midwifery instruments were of rude construction, has in the present day tendered to foster a system of unnecessary and even dangerous delay. In conclusion, I am quite confident that far fewer evils result from too early interference, than from too great delay, I will therefore venture strongly to impress upon my hearers that *laissez faire* midwifery is bad.

Dr. Barnes remarked that the choice between alternative operations must depend greatly upon the perfection to which the operations and the necessary instruments were brought. He

thought Dr. Greenhalgh had underrated the application of craniotomy as a means of avoiding resort to the Cæsarean section. He (Dr. Barnes) exhibited a pelvis of a dwarf whom he had delivered at term by Cæsarean section. These were, indeed, sad inglorious trophies. It presented the most extreme degree of contraction. The conjugate diameter was less than an inch, and the greatest space at the sides nowhere amounted to an inch and a half. Yet through this very pelvis he had that day, as a practical demonstration to his class at St. Thomas's, drawn through a seven months' fœtus of ordinary size, after perforation and removal of a portion of the cranial vault, by bringing down the face first by help of his craniotomy-forceps. In this way the head came through the chink of the brim so flattened as to offer little difficulty. The operation was done in a few minutes. The mechanism of this mode had been explained by Dr. Hicks in a paper read to the Society. This very operation now demonstrated on the pelvis he (Dr. Barnes) carried through successfully on the living subject a week ago. He had been sent for to Hampshire to deliver a dwarf whose pelvis, he believed, was scarcely larger than the one now exhibited. He induced labour at seven months, dilated the uterus by his water dilators, perforated and brought the head through face first, as described. The patient, he believed, was doing well. The whole proceeding only occupied a few hours. He believed, therefore, that in the most extreme degrees of contraction it was possible to deliver by craniotomy if labour were brought on at seven months; and that two inches' conjugate diameter was enough for a full-grown child. He quite agreed that we were not to seek to accomplish "tours de force," but to consider well what we could do safely. The experience he adduced showed, however, that in craniotomy, properly performed, we possessed a means of still further pushing aside what he found we must yet regard as a forlorn hope—the Cæsarean section.

Dr. Playfair said that, if he might venture to make a criticism on Dr. Greenhalgh's interesting paper, it would be to the effect that he had rather understated the case as to the mortality of the Cæsarean section. Dr. Playfair hazarded this statement after a careful study of his recorded cases of the operation, and especially referred to the statistics on the subject published by M. Pihan-Dufeillay, in the 18th vol. of the 'Archives Générales de Médecine.' M. Dufeillay had analysed all the cases in which the operation had been performed between the years 1845 and 1861. He had shown that of the cases operated on at an early period of labour, before the strength of the patient had been exhausted by fruitless efforts to overcome the obstruction, three fourths, or 81 per cent., recovered; while in those cases in which the patient had been long in labour, and in whom marked symptoms of exhaustion were present, only 19 per cent. were successful.

Even these last figures, it would be observed, showed a considerably larger success than had been obtained in Great Britain, where only 11 per cent. of the patients survived; and if any one would take the trouble to read over the description of the cases in which the operation had been performed in this country, and would remark the semi-moribund condition in which the patients were described to be in before the Cæsarean section was resorted to, he would see cause to be surprised, not so much at the great mortality, but rather that even this small measure of success had been obtained. Dr. Playfair did not think that M. Dufeillay's statistics should be considered as indicating anything more than an approximation to the probable mortality; but they might fairly be assumed to prove, at least, that the Cæsarean section, properly performed, need by no means be the excessively deadly operation we are generally taught to consider it. It was a curious coincidence also, if nothing more, that this estimated success of 80 per cent. was very nearly that which was found to follow ovariotomy, and he could see no reason why the one operation should be so much more fatal than the other. It might be objected that in ovariotomy we had merely incision of the abdominal parietes, while in the Cæsarean section we had in addition the incision of the uterus, and that this made all the difference. But we should remember that in ovariotomy we had the removal of the tumour itself, forming for the time an integral portion of the body, as well as the division and laceration of the frequently numerous and strong adhesions to the surrounding parts, and he thought that the risk of these two together might be considered fully to counterbalance that of the uterine incision. Dr. Playfair's principal object, however, was to refer to the question of the proper treatment of cases in which an ovarian tumour was pushed down in front of the fœtal head and obstructed delivery. He had recently occasion to deliver a patient in whom this complication occurred, and in whom the tumour could neither be pushed up above the brim of the pelvis nor be diminished in size by puncture. In that case craniotomy was performed with great difficulty, and the mother died a few days after the operation. He had since collected details of nearly fifty instances in which this complication had occurred, and found that of the cases delivered by craniotomy more than one half had terminated fatally. It might fairly be assumed that had the Cæsarean section been performed in these cases at an early period of labour the mortality would, at least, not have been greater; while, not only would we have saved the lives of the children, but we might at the same time have made a radical cure of the disease from which the patient was suffering. Even in cases in which the patient recovered from the craniotomy the disease still remained. And, in the present days of advanced abdominal

surgery, it might be considered almost certain that at no very distant period she would have to undergo another equally formidable operation for the removal of the tumour. It therefore became an important question, since we had two alternatives of nearly equal danger to the mother, whether we would not be justified in selecting the one which afforded an opportunity of radically curing the disease, as well as of saving the infant. It might even be possible to excise the tumour without opening the uterus, but this could only be settled by experience. At any rate, he thought the question was one well worthy of consideration.

Dr. EASTLAKE referred to one of Dr. Greenhalgh's cases, where, after the head had been perforated, the labour was left to the natural efforts. He wished to ask the author whether under such circumstances he had ever met with any change in the presentation of the fœtus. A case of this nature had occurred in the Rotunda Lying-in Hospital, and was recorded by Dr. Shekleton in the 'Dublin Quarterly Journal.' In that case the patient had been delivered on two or three occasions by craniotomy, owing to great disproportion, due to a pelvic tumour. On the occasion of her last labour delivery by the Cæsarean section had even been contemplated. The majority of the accoucheurs in consultation were, however, in favour of again using the perforator; accordingly the head was opened, and a large quantity of the cerebral mass evacuated. The patient was then left for a couple of hours, when, to the surprise and regret of the medical attendants, the left arm of the child was found to occupy the narrow space in the vagina. This untoward event of the altered presentation compelled them to separate the child's arm from the body, and eviscerate and extract under the greatest difficulty. The woman died within ten minutes of her delivery. At the autopsy a laceration was discovered in the posterior wall of the uterus. Dr. McClintock, who had delivered the patient in her former labours, and was present on this occasion, believed that the disproportion in the pelvis was in no way changed. The fatal issue may therefore be justly attributed to the increased difficulty of the labour, due to the altered presentation. With the experience of such a case before us, Dr. Eastlake considered that where it was thought advisable to postpone extraction after perforation it would be well to adopt some means by which the head could be fixed or tethered, so as to correspond with the pelvic aperture.

INDEX.

PAGE

Address of the President, Henry Oldham, M.D., January 4th, 1865 . 19
Address of the New President, Robert Barnes, M.D., *on taking the Chair* 37
Albuminuria, hydatidiform degeneration of the chorion associated with (Dr. B. Woodman) 113
—— ditto, ditto (Dr. Barnes) 117
Amputation of the arm in pregnancy (Mr. Napper) . . 12
Annual General Meeting, January, 1865 . . . 1, 14
Arm, amputation of the, in pregnancy (Mr. Napper) . . 12
Artery, pulmonary, embolism of, after ovariotomy (Dr. Parson) . 8
AVELING (Dr. J. H.) case of ovariotomy: pedicle tied and returned and ligature removed in forty-eight hours . . 229
—— *Discussion* on ditto 231
—— new hysterotome and intra-uterine spring tent . . 155
—— *Remarks* on Dr. M. Sims' paper on procidentia uteri . . 249

Bailey (Mr. H. W.) of Thetford, elected an Honorary Fellow . 207
BARNES (Dr.) *Address as President on taking the Chair* . . 37
—— fibroid tumour removed from the uterus by enucleation and excision 55
—— instrument for dividing the cervix uteri in dysmenorrhœa, &c. . 72
—— large fibroid tumour expelled spontaneously from the uterus several weeks after labour 113
—— case of hydatidiform degeneration of the chorion associated with albuminuria 117
—— on dysmenorrhœa, metrorrhagia, ovaritis, and sterility from a peculiar formation of the cervix uteri—treatment by dilatation or division 120
—— *Discussion* on ditto 137

PAGE

BARNES (Dr.) *Appendix* to *Paper* on dysmenorrhœa, &c., in illustration of the behaviour of the conical cervix with minute os, under labour [two cases reported by Dr. B. Woodman] . 150
—— on the varieties of form imparted to the fœtal head by the various modes of birth 171
—— uterus of a woman who died after simple tapping . . 207
—— instrument for introduction of perforated laminaria tent into cervix uteri 207
—— voluminous fibroid tumour from the uterus . . 228
—— *Remarks* on Dr. Snow Beck's paper on puerperal fever . 36
—— —— on Mr. G. Roper's paper on labour in primiparous women late in life 53
—— —— on Dr. B. Hicks's paper on the mento-posterior position in face presentation 67
—— —— on Dr. Meadows's paper on the influence of maternal impressions on the fœtus 94
—— —— on Mr. E. B. Truman's case of extra-uterine fœtation . 168-9
—— —— on Dr. M. Sims' paper on procidentia uteri . 219, 251
—— —— on Dr. Greenhalgh's paper on the Cæsarean operation and craniotomy 286
—— and Dr. B. HICKS, *Report* on Dr. Hicks' case of extra-uterine fœtation 100
Baudelocque's cephalotribe, its presentation to the Society . 208
BECK (Dr. Snow) on puerperal fever 31
—— *Discussion* on ditto 35
BERRY (Prof.) two cases of obstructed labour, with remarks . 261
—— *Discussion* on ditto 286
Bowel, imperforate, operation, death (Dr. A. Meadows) . . 53
BROWN (Mr. I. Baker) on a new method of securing the pedicle in ovariotomy 28
—— *Discussion* on ditto 28
—— *Remarks* on Dr. Barnes's paper on dysmenorrhœa and division of the cervix uteri 137
BROWN (Mr. I. B.), Jun. preparation of chloroform for administration during labour 208
—— *Remarks* on Dr. M. Sims' paper on procidentia uteri . 220, 249
Bye Laws, additions to, relative to the Library . . . 15

Cæsarean section in case of extreme distortion of the pelvis (Dr. Greenhalgh) 220
—— and craniotomy, their comparative merits in extreme distortion of the pelvis (Dr. Greenhalgh) 270
Cephalotribe of Baudelocque, its presentation to the Society . 208

PAGE

Cervix uteri, non-evoluted, and hypertrophied state of, in difficult case of labour (Mr. G. Roper) 233
—— conical, with minute os, its behaviour under labour, two cases (Dr. B. Woodman) 150
—— dysmenorrhœa, &c., from peculiar formation of; treatment by dilatation or division (Dr. Barnes) . . . 120
—— growth removed from (Dr. Greenhalgh) . . . 255
—— instrument for dividing, in dysmenorrhœa, &c. (Dr. Barnes) . 72
—— instrument for introduction of laminaria tent into (Dr. Barnes) 207
Chambers (Mr.) *Remarks* on Dr. M. Sims' paper on procidentia uteri 250
Chancre on the os uteri (Dr. B. Woodman) 26
Chloroform, preparation of, for administration during labour (Mr. I. B. Brown, jun.) 208
Chorea, combination of, with pregnancy (Dr. B. Woodman) . 102
Chorion, hydatidiform degeneration of, associated with albuminuria (Dr. B. Woodman) 113
—— Ditto, ditto (Dr. Barnes) . . 117
Conversazione in March, 1866, *announcement of* . . 227
Craniotomy in case of extreme distortion of the Pelvis (Dr. Greenhalgh) 220
—— and the Cæsarean operation, their comparative merits in extreme distortion of the pelvis (Dr. Greenhalgh) . . 270
Curette, new form of, for removal of uterine fungoid granulations (Dr. M. Sims) 72
Cyst, Dermoid, portion of, passed per rectum (Dr. T. Smith) . 45
—— —— attached to right ovary (Dr. B. Woodman) . . 158
—— —— developed in the Fallopian tube (Dr. Ritchie) . 254

Dermoid, see *Cyst*.
Dysmenorrhœa, &c., from peculiar formation of the cervix uteri: treatment by dilatation or division (Dr. Barnes) . . 120

Eastlake (Dr.) *Remarks* on Dr. Greenhalgh's paper on the Cæsarean operation and craniotomy 289
Ecraseur, improvement in fastening the rope in that of Dr. B. Hicks . 71
Ellection of New Fellows . 1, 25, 45, 71, 95, 113, 155, 207, 227, 253
—— *of an Honorary Fellow* [H. W. Bailey of Thetford] . . 207
Ellis (Mr. Richard), on a rare form of twin monstrosity . . 160
Embolism of the pulmonary artery, after ovariotomy (Dr. Parson) . 8

Fallopian tube, dermoid cyst developed in (Dr. Ritchie) . . 254
Fever, see *Puerperal* Fever.

PAGE

Fœtal membranes, attachment of to the scalp in case of monstrosity (Dr. Tanner) 109
Fœtation, see *Pregnancy*.
Fœtus, influence of maternal impressions on (Dr. Meadows) . 84
—— laceration of the integument of, during delivery (Mr. King Peirce) 74
—— varieties of form imparted to head of, by the various modes of birth (Dr. Barnes) 171
—— anencephalic (Mr. H. Hailey) 78
—— monstrous, see *Monstrosities*.
Funis, vascular erectile tumour in sheath of, in an infant (Mr. Lawton) 210

Gayton (Mr. William) case of monstrosity 56
Granulations, fungoid, of uterus, new curette for removal (Dr. M. Sims) 72
Greenhalgh (Dr.) removal of a polypus 25
—— new form of uterine tent from the stem of the laminaria spiralis, and new pelvimeter 72
—— case of extreme distortion of the pelvis, craniotomy, cephalotripsy, Cæsarean section 220
—— growth removed from the cervix uteri 255
—— large fibrous polypus 256
—— on the comparative merits of the Cæsarean operation and craniotomy in cases of extreme distortion of the pelvis . . 270
—— *Discussion* on ditto 286
—— *Remarks* on Dr. Barnes's paper on dysmenorrhœa and division of the cervix uteri 138

Hailey (Mr. Hammett) case of anencephalic fœtus . . 78
Hall (Dr.) *Remarks* on Dr. M. Sims' paper on procidentia uteri . 219
Harley (Dr. Geo.) and Dr. A. Meadows, *Report* on Mr. King Peirce's case of laceration of the integument of the fœtus during delivery 76
Harris (Mr. A.) membrane expelled from uterus a few days before delivery at full term 47
—— *Report* on ditto, by Dr. G. Hewitt and Dr. A. Meadows . 48
Head, fœtal, varieties of form imparted to, by the various modes of birth (Dr. Barnes) 171
Hernia cerebri and hernia umbilicalis, with attachment of fœtal membranes to the scalp (Dr. Tanner) 109
Hewitt (Dr. Graily) anteflexion of the gravid uterus . . 170

PAGE
HEWITT (Dr. G.) *Remarks* on Dr. Snow Beck's paper on puerperal fever . 35
—— —— on Dr. Hicks' case of extra-uterine fœtation . . 99
—— —— on Dr. Woodman's case of hydatidiform degeneration of the chorion 117
—— —— on Dr. Barnes's paper on dysmenorrhœa and division of the cervix uteri 143
—— —— on Mr. E. B. Truman's case of extra-uterine fœtation . 169
—— and Dr. A. MEADOWS' *Report* on Mr. A. Harris's case of membrane expelled from the uterus . . . 48
HICKS (Dr. Braxton) on two cases of face presentation in the mento-posterior position, with remarks . . . 57
—— *Discussion* on ditto 67
—— improvement in fastening the rope in his écraseur . . 71
—— on a rare form of extra-uterine fœtation . . . 95
—— *Discussion* on ditto 98
—— *Report* on ditto, by Dr. Barnes and Dr. Braxton Hicks . 100
—— large fibrous tumour of uterus; spontaneous sloughing; death from peritonitis 110
—— microscopical examination of vascular erectile tumour in the sheath of the funis 213
—— polypus weighing two and a quarter pounds . . 253
—— *Remarks* on Mr. E. B. Truman's case of extra-uterine fœtation 168
Hydatiform degeneration of the chorion, associated with albuminuria (Dr. B. Woodman) 113
—— ditto, ditto (Dr. Barnes) 117
—— degeneration of the ovum (Dr. Russell) . . . 228
Hysterotome, new (Dr. Aveling) 155

Imagination, mother's, influence of, on the fœtus in utero (Dr. Meadows) 84
Instruments, obstetric, announcement of conversazione for exhibition of . 227
Instruments for operations on the uterus and vagina (Messrs. Weiss) 157
Intestine, imperforate, operation, death (Dr. A. Meadows) . 53

Labour in primiparous women, late in the reproductive period of life (Mr. G. Roper) 51
—— premature, in case of œdema of lower half of the body after a fall in seventh month of pregnancy (Dr. A. Rasch) . . 80
—— difficult case of, with non-evoluted and hypertrophied state of the cervix (Mr. G. Roper) 233
—— obstructed, two cases of, with remarks (Professor Berry) . 261
Laceration of the integument of the fœtus during delivery (Mr. King Peirce) 74

PAGE

Laminaria tent, instrument for its introduction into cervix uteri (Dr. Barnes) 207
LAWTON (Mr. F.) vascular erectile tumour in sheath of funis in a new-born infant 210
—— microscopical examination of ditto by Dr. Hicks . . 213
Library, additions to the Bye Laws relative to . . . 15
List of Officers elected for 1865 18
—— ——*for* 1866 v
—— *of Honorary Fellows* ix
—— *of Ordinary Fellows* xi
—— *of Deceased Fellows*, 1864 20
—— *of Referees of Papers* vii
—— *of Honorary Local Secretaries* viii

MARTYN (Dr. Williams) *Remarks* on Dr. B. Hicks's Paper on the mento-posterior position in face presentation . . 68
—— —— on Dr. Meadows' Paper on the influence of maternal impressions on the fœtus 92
MEADOWS (Dr. Alfred) case of imperforate bowel, operation, death . 53
—— case of monstrosity, with remarks on the influence of maternal impressions on the fœtus in utero . . . 84
—— *Discussion* on ditto 92
—— see *Harley* (Dr. G.)
—— see *Hewitt* (Dr. G.)
Meeting, Annual General, January, 1865 . . . 1, 14
Membrane expelled from uterus a few days before delivery at full term (Mr. A. Harris) 47
Mento-posterior position, in face presentation (Dr. B. Hicks) . 57
Metrorrhagia, &c., from peculiar formation of the cervix uteri (Dr. Barnes) 120
Monstrosity, case of (Mr. Wm. Gayton) 56
—— ditto (Mr. Thane) 227
—— case of, with remarks on the influence of maternal impressions on the fœtus in utero (Dr. Meadows) . . . 84
—— anencephalic (Mr. H. Hailey) 78
—— double, with account of the delivery (Mr. W. Wills) . . 6
—— twin, a rare form of (Mr. Richard Ellis) . . . 160
—— with hernia cerebri, and hernia umbilicalis, and attachment of fœtal membranes to the scalp (Dr. Tanner) . . 109

NAPPER (Mr. Albert) amputation of the arm in pregnancy . 12
NUNN (Mr.) *Remarks* on Dr. M. Sims' Paper on procidentia uteri . 248

PAGE
Occipital region, serous tumour in (Mr. J. Waits) . . 158
Œdema of lower half of body after a fall in seventh month of pregnancy, &c. (Dr. A. Rasch) 80
OLDHAM (Dr. Henry), *Annual Address as President*, January 4th, 1865 19
Os uteri, case of chancre on, (Dr. B. Woodman) . . . 26
Ovarian dropsy, case of, ovariotomy, recovery (Mr. Sharpin) . 105
Ovariotomy, recovery (Mr. Sharpin) 105
—— on a new method of securing the pedicle in (Mr. B. Brown) . 28
—— pedicle tied and returned, and ligature removed in forty-eight hours (Dr. Aveling) 229
—— embolism of the pulmonary artery after (Dr. Parson) . 8
Ovaritis, &c., from peculiar formation of the cervix uteri (Dr. Barnes) 120
Ovum, hydatiform degeneration of the (Dr. Russell) . . 228

PARSON (Dr. E.) case of embolism of the pulmonary artery after ovariotomy 8
—— *Discussion* on ditto 10
—— *Remarks* on Mr. B. Brown's paper on securing the pedicle in ovariotomy 30
Parturition, see *Labour*.
Pedicle, new method of securing, in ovariotomy (Mr. B. Brown) . 28
—— tied and returned, and ligature removed in forty-eight hours in case of ovariotomy (Dr. Aveling) 229
PEIRCE (Mr. King) case of laceration of the integument of the fœtus during delivery 74
—— Report on ditto, by Dr. G. Harley and Dr. Meadows . 76
Pelvimeter, new (Dr. Greenhalgh) 72
Pelvis, extreme distortion of, craniotomy and Cæsarean section (Dr. Greenhalgh) 220
—— —— comparative merits of the Cæsarean operation and craniotomy in (Dr. Greenhalgh) 270
Peritonitis, death from, in a case of sloughing of fibrous tumour of uterus (Dr. B. Hicks) 110
Pessaries (Medicated) suggested by Professor Simpson . . 208
Placenta, abnormal variety of the battle-dore (Dr. U. West) . 257
PLAYFAIR (Dr. W. S.), case of extra-uterine fœtation . . 1
—— *Remarks* on Mr. E. B. Truman's case of extra-uterine fœtation . . . . . 168—9
—— —— on Dr. Greenhalgh's paper on the Cæsarean operation and craniotomy 287
Polypus, removal of a (Dr. Greenhalgh) 25
—— weighing two and a quarter pounds (Dr. B. Hicks) . . 253
—— large fibrous (Dr. Greenhalgh) 256

PAGE
Pregnancy, amputation of the arm in, (Mr. Napper) . . 12
—— combination of chorea with, (Dr. B. Woodman) . . 102
—— fall in seventh month of, subsequent œdema of the lower half of the body, &c., (Dr. A. Rasch) 80
—— case of twin, (Dr. J. Way) 209
—— extra-uterine, (Dr. Playfair) 1
—— case of extra-uterine, (Mr. E. B. Truman). . . 164
—— extra uterine, on a rare form of, (Dr. B. Hicks) . . 95
Presentation, face, in the mento-posterior position, two cases, (Dr. B. Hicks) 57
Priestley (Dr.) *Remarks* on Dr. Playfair's case of extra-uterine fœtation 5
Primiparæ, labour in, late in the reproductive period of life (Mr. G. Roper) 51
Procidentia uteri (Dr. M. Sims) . . 213, 238
Puerperal fever, on (Dr. Snow Beck) 31

Rasch (Dr. Adolph) case of œdema of the lower half of the body, after a fall in seventh month of pregnancy, premature labour, recovery 80
—— *Remarks* on Dr. Meadow's paper on the influence of maternal impressions on the fœtus 93
—— —— on Dr. Hicks' case of extra-uterine fœtation . . 99
—— —— on Dr. M. Sims' paper on procidentia uteri . . 249
Report of the Auditors for 1864 14
Richardson (Dr. B.) *Remarks* on Dr. Parson's case of embolism after ovariotomy 11
Ritchie (Dr.) dermoid cyst developed in the Fallopian tube . 254
—— *Remarks* on Mr. E. B. Truman's case of extra-uterine fœtation 169
Roper (Mr. George) labour in primiparous women late in the reproductive period of life 51
—— difficult case of labour with non-evoluted and hypertrophied state of the cervix uteri 233
—— *Remarks* on Mr. E. B. Truman's case of extra-uterine fœtation 167
Rouse (Mr. John) recovery of a still-born child; marking of the skin simulating the effects of injury 45
Routh (Dr.) fibro-cystic disease of the uterus . . . 253
—— *Remarks* on Mr. B. Brown's paper on securing the pedicle in ovariotomy 30
—— —— on Dr. Hicks' case of extra-uterine fœtation . . 98
—— —— on Dr. Barnes's paper on dysmenorrhœa and division of the cervix uteri 139
Russell (Dr.) hydatiform degeneration of the ovum . . 228

PAGE

SAVAGE (Dr.) *Remarks* on Dr. Barnes's paper on dysmenorrhœa and division of the cervix uteri 140
—— —— illustrative anatomical description of a virgin uterus . 140
SHARPIN (Mr. H. W.) case of ovarian dropsy; ovariotomy; recovery 105
SIMS (Dr. Marion) on a new form of curette for the removal of uterine fungoid granulations 72
—— on procidentia uteri 213
—— *Discussion* on ditto 218
—— on procidentia uteri 238
—— *Discussion* on ditto 248
—— *Remarks* on Dr. Barnes's paper on dysmenorrhœa and division of the cervix uteri 144
—— —— on Dr. Aveling's case of ovariotomy . . 232
Skin, marking of, simulating the effects of injury, in a still-born child (Mr. J. Rouse) 45
Sloughing, spontaneous, in a case of large fibrous tumour of uterus (Dr. B. Hicks) 110
SMITH (Dr. Tyler) portion of a dermoid cyst, with teeth attached, passed per rectum 45
—— *Remarks* on Dr. Meadows' paper on the influence of maternal impressions on the fœtus 94
Sterility, &c., from peculiar formation of the cervix uteri (Dr. Barnes) 120
Still-born child, recovery of; marking of the skin, simulating the effects of injury (Mr. J. Rouse) . . . 45

TANNER (Dr. T. H.) hernia cerebri and hernia umbilicalis with attachment of the fœtal membranes to the scalp . . 109
THANE (Mr.) monstrous fœtus 227
Tent, uterine, from the laminaria spiralis (Dr. Greenhalgh) . 72
—— intra-uterine spring (Dr. Aveling) . . . 155
TRUMAN (Mr. Edgar B.) case of extra-uterine fœtation . . 164
—— *Discussion* on ditto 167
Tumour, vascular erectile, in sheath of funis in a new-born infant (Mr. Lawton) 210
—— microscopical examination of ditto (Dr. B. Hicks) . . 213
—— large fibrous, of uterus, spontaneous sloughing (Dr. B. Hicks) . 110
—— fibroid, in a uterus (Dr. B. Woodman) . . . 26
—— large fibroid, expelled from uterus spontaneously (Dr. Barnes) . 113
—— fibroid, removed from the uterus by enucleation and excision (Dr. Barnes) 55
—— voluminous fibroid, from the uterus (Dr. Barnes) . . 228
—— serous, in the occipital region (Mr. J. Waits) . . 158

PAGE

TURNER (Mr. Sidney) *Remarks* on Dr. M. Sims' paper on procidentia uteri 218
Twin monstrosity, a rare form of (Mr. Richard Ellis) . . 160
Twin pregnancy, case of (Dr. J. Way) . . . 209

Uterus of a woman who died after simple tapping (Dr. Barnes) . 207
—— membrane expelled from, a few days before delivery at full term (Mr. A. Harris) 47
—— gravid, anteflexion of (Dr. G. Hewitt) . . . 170
—— procidentia of (Dr. M. Sims) . . . 213, 238
—— fibro-cystic disease of (Dr. Routh) . . . 253
—— voluminous fibroid tumour from (Dr. Barnes) . . 228
—— fibroid tumour removed from, by enucleation and excision (Dr. Barnes) 55
—— fungoid granulations of, new curette for removal of (Dr. M. Sims) 72
—— instruments for operations on 157
—— see *Os Uteri, Cervix Uteri.*

Vagina, instruments for operations on . . . 157

WAITS (Mr. J.) serous tumour in the occipital region . . 158
WAY (Dr. John) case of twin pregnancy . . . 209
WELLS (Mr. Spencer) *Remarks* on Dr. Parson's case of embolism after ovariotomy 10
—— *Remarks* on Dr. Aveling's case of ovariotomy . . 231
—— *Remarks* on Dr. M. Sims' paper on procidentia uteri . 248
WEST (Dr. Uvedale) abnormal variety of the battle-dore placenta . 257
WILKINS (Dr.) of Williams Town, Australia, *Remarks* on Dr. M. Sims' paper on procidentia uteri 250
WILLIAMS (Dr. Wynn) *Remarks* on Dr. Barnes's paper on dysmenorrhœa 143
—— *Remarks* on Dr. M. Sims' paper on procidentia uteri . 249
WILLS (Mr. W.) double monstrosity, with account of delivery . 6
WOODMAN (Dr. B.) fibroid tumours in a uterus . . . 26
—— case of chancre on the os uteri 26
—— on the combination of chorea with pregnancy . . 102
—— two cases of hydatidiform degeneration of the chorion, with albuminuria 113
—— dermoid cyst attached to right ovary . . . 158
—— *Appendix* to Dr. Barnes's paper on dysmenorrhœa: behaviour of the conical cervix with minute os under labour . . 150

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1844. *Sydenham*, Opera, a. Greenhill.
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1844. *Erichsen* (J.) Selections on Aneurism.
1845. *Simon* (F.) Animal Chemistry; translated by Day.
1846. *Hasse* (C. E.) Diseases of the Organs of Circulation and Respiration; translated by Swaine.
1846. *Hewson* (W.) Works; edited by Gulliver.
1847. *Dupuytren*, Injuries of Bones; translated by Le Gros Clark.
1847. *Harvey's* (W.) Works; translated by Rt. Willis.
1847. *Feuchtersleben*, Medical Psychology; edited by B. G. Babington.
1847. *Schwann*, Microscopical Researches; translated by Spencer Smith.
1848. *Sydenham's* Works; translated by Latham.
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[1848. *Rhazes*, on Smallpox and Measles; translated by Greenhill.]
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1853. *Romberg* (M. H.) on Nervous Diseases; translated by Sieveking.
1853. *Kolliker's* Human Histology; translated by Busk and Huxley.
1854. *Dupuytren*, Lesions of Vascular System; translated by Le Gros Clark.
1855. *Wedl's* Pathological Histology; translated by Busk.
1855. *Œsterlen's* Medical Logic; translated by G. Whitley.
1856. *Aretaeus'* Works; translated by F. Adams.
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1857. *Siebold*, on Tape and Cystic Worms; translated by Huxley.

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		Presented by
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(Signed)

ALFRED MEADOWS, M.D.,
Hon. Librarian.

192, PICCADILLY,
December, 1865.

INDEX

TO THE

CATALOGUE OF THE LIBRARY

OF THE

OBSTETRICAL SOCIETY OF LONDON;

CONTAINING

AN ALPHABETICAL LIST OF SUBJECTS,

WITH THE

NAMES OF AUTHORS.

*** *The Catalogue is at the end of Volume IV of the 'Transactions,' with additions in the subsequent Volumes.*

ABDOMEN
Surgery of: Ashwell (Blundell).
Dropsy of: See ASCITES.
ABORTION: Burns, Granville, Power, Whitehead.
—— *Plates:* Granville.
ABSCESS
(*Mammary or Milk*): Nunn.
ACID
(NITROUS)
—— *in Syphilis:* Ferriar's Med. Histories.
AEROSTATION
by Mr. James Deeker, at Norwich, 1785: Rigby.
—— *Major Money, ditto:* Rigby.
ÆTHER: See ETHER.
AFRICA
(SOUTH)
—— *Diseases at North Victoria,* 1851-2: Black (W. T.).
(GOLD COAST)
—— *Topography and Diseases:* Clarke (R.).
ALCHEMY: Culpepper.
ANÆSTHETICS: Kidd (C.).
in Surgery: Simpson.
in Midwifery: Simpson.
See CHLOROFORM; ETHER.
ANASARCA: Ayre.

ANATOMY
Systems of: 'Anatomy,' Aretæus (Ruffus Ephesius), Gerber.
Progress of, 1841-6: Paget.
Nomenclature: Barclay (J.).
Essays, &c.: Druitt.
(MICROSCOPICAL): See HISTOLOGY.
(PATHOLOGICAL or MORBID); Hasse, Hope (J.). Rokitansky.
—— *Plates:* Camper, Hope (J.).
(COMPARATIVE): Gerber.
ANEURISMS: Abernethy (J.), Erichsen.
ANIMATION (SUSPENDED): See ASPHYXIA.
ANUS
Fissure of, in children: Gautier.
AORTA
Compression of: Baudelocque.
APOPLEXY
(PULMONARY): Smith (J. R.).
ARM
Pathological Anatomy of: Camper.
ARTERIES
Anatomy and Functions: Murray (A.).
Systolic Murmur in Pulmonary, use in diagnosis: Ormerod.
Diseases, &c.:
—— *Inflammation and Obstruction of Branches of Pulmonary:* Kidd (G. H.).
—— *Treatment:*
—— *by Ligature of Internal Carotid:* Keith (W.).
ASCITES: Ayre.
ASPHYXIA: Kay.
—— *of New-born Infants:* Craig.
AUSCULTATION
(OBSTETRIC): Hohl, Kennedy (E.), Naegele (H. F.).
—— See PREGNANCY.

BATHS
(SULPHUREOUS)
—— *at Sandefjord, Norway:* Ebbesen.
See MINERAL WATERS.
BIBLIOGRAPHY
Medical and Surgical: Ploucquet.

BIOGRAPHY
Medical: Memoirs.
BLOOD
Properties of: Hewson.
Red Particles of: Hewson.
Serum of: Hildanus.
Coagulation of: Hewson.
(CIRCULATION OF): Harvey's Works.
BLOOD VESSELS
Pathological Anatomy of: Hasse, Rokitansky (vol. 4).
Lesions and Injuries: Dupuytren.
BONES
Anatomy of: Ward.
Pathological Anatomy of: Rokitansky (vol. 3).
Injuries and Diseases: Dupuytren.
Softening of: Litzmann.
—— *of the Pelvis, hindering parturition:* Radford, Spengel.
BOTANY
(*Anatomical and Physiological*): Schleiden, Schwann.
BRAIN: Kirkland (T.).
Dropsy of: See HYDROCEPHALUS.
BREAST
Diseases: Velpeau.
Abscess of: Nunn.
Inflammation of: Nunn.
BRONCHOCELE: Wilmer.
BULAM FEVER
Non-existence of, as distinct from Yellow Fever: Bancroft.

CÆCUM
Inflammation of: Wilhelmi.
CÆSAREAN SECTION: Baudelocque, Clay (C.), Clay (Goodman), Hull (J.), Kayser, Naegele (H. F.), Radford, Reuter (C.), Schultze, Smiles, Vaughan.
Question of its adoption v. *Craniotomy:* Levy, Naegele (F. C.).
CALCULI
(URINARY)
—— *Chemical Examination of:* Peter.
CANCER: Walshe, Young (S.).
Treatment.
—— *by Congelation:* Arnott.

CANCER—*continued.*
Treatment—continued.
—— *by Pressure and Natural Separation:* Young (S.).
—— *by Vegetable Regimen:* Lambe (W.).
of the Tongue: Keith (W.).
of the Female Sexual Organs: Tanner.
(COLLOID)
—— *of the Ovary:* Virchow.

CANCRUM ORIS: See NOMA.

CANINE MADNESS: See RABIES.

CAULIFLOWER EXCRESCENCE
of the os Uteri: Simpson.

CEPHALOTRIPSY: Curchod, Baudelocque.
See CRANIOTOMY.

CERVIX UTERI: See UTERUS (Cervix).

CHARITIES (MEDICAL)
of the Metropolis: Memoirs.

CHEMISTRY
Treatises: Parkes.
(ANIMAL): Simon (F.).

CHEST
Dropsy of: See HYDROTHORAX.

CHILDBED: See PARTURITION.

CHILDREN
Hygienic Treatment: Barker (T. H.), Dewees, Haden, Kennedy (J.), Roberton, Scevola, Struve.
—— (*Psychical*): Dewees.
—— (*Moral and Educational*): Nelson (J.).
Diseases: Armstrong (G.), Astruc, Burns, Campbell (W.), Cheyne, 'Children' (Harris, Boerhaave, &c.), Clarke (J.), Davis (D.), Dease (W.), Haden, Hamilton (J.), Henke (A.), Marley, Pearce, Rigby, jun., Rosen, Underwood, West.
Mortality of: See MORTALITY.

CHINCOUGH: See HOOPING COUGH.

CHLOROFORM
as an Anæsthetic: Kidd (C.).
Importance of the Pulse in relation to: Dyce.

CHLOROSIS: Ashwell, Fox (S.).

CINCHONA
Properties and use:
—— *in Intermittent Fever:* Rigby (E.).

CIRCULATION (ORGANS OF THE)
Diseases, &c.: Hasse, Rokitansky (vol. 4).
See BLOOD VESSELS, &c.
CLUB FOOT
Congenital: Scarpa.
CLYSTERS: Graaf.
COCCYX
Coccyodynia: Faye.
COLIC
(LEAD OR PAINTERS'.)
—— *Endemic of Devonshire:* Huxham.
COMPENSATION, LAW OF: Channing.
CONCEPTION: Clay (Harvey), Harvey's Works.
See GENERATION.
CONCRETIONS
Animal: Taylor (T.).
See CALCULI.
CONSUMPTION (PULMONARY): See PHTHISIS.
CONTAGION
(*Acute*): Blackburne.
(*Febrile*): Bancroft.
—— See FEVERS.
CONVULSIONS
(PUERPERAL): Denman, Hodges (R.), Leake, Lever.
—— *Uræmic:* Braun.
CORONERS' INQUESTS
Law &c. of: Sewell, Taylor, (A. S.).
CORPULENCY
during Pregnancy: Chambers (T. K.).
COUGH
See HOOPING COUGH.
COUNTER-IRRITATION: See REVULSION.
COWPER'S GLANDS
in the Female: Tiedemann.
COW-POX: Bell (G.), Bruce, Jenner.
See VACCINATION.
CRANIOTOMY: Müller (J. C.), Baudelocque (A.),
Medico-Legal Question as to its adoption: Levy, Naegele (F. C.).
See FŒTUS (Decapitation of), CEPHALOTRIPSY.
CRANIUM
Growth in Utero: Crève.
Fontanelles of:
—— *their disappearance before Parturition:* Crève.

CROTON OIL
Poisoning by: Keith (G. S.).
CROUP: Ferriar's Med. Histories, Schaible, Ware (J.).
Tracheotomy in: Schaible.
See LARYNGISMUS.
CUTANEOUS DISEASES: See SKIN (Diseases of).

DEBILITY
General: Smee (A.).
DEFORMITIES: Gusserow.
See MONSTERS.
DELIVERY: See PARTURITION.
DIABETES: Ormerod.
DICTIONARIES
of Medicine: Copland, Cyclopædia, Parr.
—— *Terms:* Mayne.
of Science
—— *Terms:* Mayne.
DIET AND REGIMEN: Thackrah.
(VEGETABLE.)
—— *in Cancer*: Lambe (W.).
DIGESTION: Thackrah.
DIGITALIS PURPUREA
Use
——*in Dropsies:* Quin.
DISEASES
(ACUTE): Aretæus, Sydenham.
(CHRONIC): Aretæus.
(HEREDITARY): Steniau, Whitehead.
(LOCAL): Abernethy.
of particular parts, kinds, &c.: See under their names.
DISPENSARIES
for Infant Poor: Armstrong (G.).
DROPSY: Ayre.
Use of Digitalis in: Quin.
See ANASARCA, ASCITES.
of the Brain: See HYDROCEPHALUS.
of Ovaries: See OVARIAN DROPSY.
of Uterus: See UTERUS.
DROWNING: Brodie (vol. 1).
DYSENTERY
Pathology and treatment: Baly, Bancroft, Douglas (J. C.). Hildani opera.

DYSMENORRHŒA: See MENSTRUATION (Difficult).

EAR
Diseases of: Warden (A.).
—— *Use of Prismatic Reflection in investigating:* Warden.
Present state of: "Aural Surgery."
ECLAMPSIA NATANS: Clay (Newnham).
ECONOMY
the Female: Power.
—— see WOMEN.
ECZEMA, INFANTILE: Wilson (E.).
EMBRYO
Embryology: Flourens, Müller (J.).
See OVUM.
EMBRYOTOMY: Hull.
EMBRYULCIA: Hull.
EPIDEMICS
of the Middle Ages: Hecker.
1675—80: Sydenham.
1728—37 *at Plymouth:* Huxham.
See FEVERS.
EPIGLOTTIS
Diseases of: Gibb.
ERGOT OF RYE
Use in Difficult Parturition: Michell (W.).
ETHER
as an Anæsthetic: Kidd.
—— *in Surgical Operations:* Snow.
—— *in Parturition:* Channing.
EXCISION
of Knee-joint: Keith (W.).
EXOSTOSIS
Difficult Parturition from: Haber.
EYE
Ophthalmic Memoranda: Foote (J.).
Diseases: Underwood.

FALLOPIAN TUBES
Unnatural Patency of Inner Extremity: Duncan (J. M.).
Rupture of Left: Wagstaffe.

FECUNDITY
Variations of, in Women, according to Age: Duncan (J. M.).
FEMALES: See WOMEN.
FEVERS: Huxham.
Sol-Lunar Influence in: Balfour (F.).
(EPIDEMIC)
—— *at Liverpool,* 1844: Watson.
(ERUPTIVE): Fuller.
(INTERMITTTENT)
—— *treated by Red Peruvian Bark:* Rigby.
(NERVOUS): Huxham.
(PUERPERAL): See PUERPERAL FEVER.
(PUTRID): Huxham.
(REMITTENT)
—— *of Infants:* Smith (R.).
—— *Bilious:* Bartlett (E.).
(YELLOW): See YELLOW FEVER.
FIBRE
Structure of: Baglivus.
Diseases of: Baglivus.
FIBROUS POLYPI: See POLYPI.
FISTULÆ
(*Congenital*): Clay (Dzondi).
—— *of the Neck:* Clay (Ascherson).
Vesico-Vaginal: Brown (B.).
FLOODING AFTER DELIVERY: See HÆMORRHAGE (Uterine).
FLUOR ALBUS: See LEUCORRHŒA.
FŒTATION
(EXTRA-UTERINE). See PREGNANCY (Extra-uterine).
FŒTICIDE: Severn.
FŒTUS
Physiology and Development: Needham, Ridge (B.).
—— *Anatomical relations with Mother:* Jones (T. W.), Madge (H.), Ritgen.
—— *Circulation of Blood in:* Jones (T. W.).
—— *Nutrition:* Stalpartius.
—— *Spontaneous evolution:* Douglas (J. C.), Gooch (R.).
—— *Question of Proof of life in Utero:* Kennedy (E.).
—— See VIABILITY of Fœtus.
Diseases
—— *in Utero:* Madge.

FŒTUS—*continued.*
Diseases—continued.
—— *Peritonitis:* Simpson.
—— *Inflammatory origin of Hernia and Malformation:* Simpson.
Decapitation of: Küneke.
FORCEPS
(OBSTETRIC): Leake, Mulder.
—— *Long:* Radford.
—— *Dr. Smellie's Wooden:* Douglas (W.), Smellie.
FORMULÆ
Medical: Spillan.
FOTHERGILLIAN PRIZE ESSAYS: Bennett (J.R.).
FUROR UTERINUS. See NYMPHOMANIA.

GALVANISM
Influence on the action of the Uterus during Labour: Simpson.
GANGRENE: Hildanus, Underwood, White (C.).
GENERATION
Physiology, &c. of: Flourens, Harvey (W.), Jörg, Moore (W.), Müller (J.).
of animals: Harvey.
See EMBRYO, FŒTUS.
(ORGANS *of*)
—— *of Men:* Graaf.
—— *of Women:* Graaf.
—— (*External*)
—— *Blood Tumours of:* Naegele (F. C.).
GESTATION. See PREGNANCY.
GOLD
Aurum potabile: Culpepper.
GOUT: Sydenham (opera).
Gouty Concretions: Ure (A.).
GULSTONIAN LECTURES
1847: Baly.

HÆMATOCELE
Peri-uterine: Breslau.
HÆMOPTYSIS: Smith (J. R.).

HÆMORRHAGE
(UMBILICAL): Radford.
(UTERINE): Burns (J.), Clay (Christie), Craig, Denman, Ingleby, Leake, Lever, Rigby (E.), Stewart (D.).
—— *after delivery:* Earle, Lever, Simpson.
—— *in Pelvic Cavity:* Gautier.
—— *into Peritonæum:* Glover.
HÆMORRHOIDS: Salmon (F.).
HEAD
Surgical Diseases of: Ottley.
HEART
Ganglia and Nerves of: Lee (R.).
Motion of: Harvey's Works.
HEAT
(ANIMAL)
—— *Theory of its production:* Rigby.
—— *Use in treatment of Cutaneous Eruptions:* Rigby.
HEREDITARY DISEASES: Steinau, Whitehead.
Hereditary tendency to Crime: Steinau.
HERNIA
(STRANGULATED): Keate (T.).
of the Bladder: Keate (T.).
HISTOLOGY: Gerber, Schwann.
(*Human*): Kölliker.
Pathological: Wedl.
HOMŒOPATHY, *works against:* Brodie (Vol. 1).
HOOPING COUGH: Ferriar's Med. Histories, Watt (R.).
HOSPITALS
On Hospital Practice: Bardsley.
Vital and Economical Statistics of: Buckle (F.).
(LYING-IN): See MIDWIFERY (Institutions, &c.).
HUMOURS (ANIMAL)
of the Human Body: Plenck.
HUNTERIAN SOCIETY ORATIONS: Conquest.
HYDROCELE
of Tunica Vaginalis Testis: Else, Keate (T.).
HYDROCEPHALUS: Ayre, Bennett (J. R.), Cheyne, Golis, Griffith, Quin, Smith (J. R.).
HYDROPHOBIA: Bardsley, Vaughan.
HYDROSIS: Channing.
HYDROTHORAX: Ayre.
HYGIENE: Hildanus.

HYOID BONE
Diseases and Injuries: Gibb.
HYPOCHONDRIASIS: Reid (John).
HYSTERIA: Tate.
HYSTERITIS: See UTERUS (Inflammation of).
HYSTEROTOME
Use in Uterine Disease: Routh (C. H. F.).

IMPOTENCY (CONJUGAL): Smith (J. R.).
INDUCTION
Method of, in Medicine: Ferguson (R.).
INFANTICIDE
Medical Jurisprudence of: Lecieux, Severn.
Sign of, in New-born Children: Mahon.
INFANTS
Hygienic Treatment, Physiological Management, &c.: Armstrong (G.), Barker (T. H.), Boer, Combe, Darwall, Moss (W.), Struve, Syer, Underwood, Weatherhead.
—— See NURSING.
Moral Management: Combe.
SUCKLING OF: Grenser, Morton (E.), Weatherhead.
—— *Disorders from:* Morton (E.).
—— *Mortality from want of:* Routh.
Artificial Feeding: Routh.
—— *a cause of Laryngismus:* Reid (J.).
Diseases: Armstrong (G.), Ballard (T.), Guillimeau, Hamilton (J.), Harris (W.), Underwood, West.
—— *the most fatal:* Armstrong (G.)
—— *new explanation of [Fruitless Sucking]:* Ballard (T.).
INFLAMMATION
Surgical Treatment of: Bell (B.).
of the Breast: Nunn.
of the Ovaries: Tilt.
of the Pelvis.
—— *after delivery:* Lever.
INFLUENZA, OR, EPIDEMIC CATARRHAL FEVER
in Great Britain, 1510—1837: Thompson (Theoph.).
INOCULATION
(VARIOLOUS): Dimsdale, Fuller, Haygarth.
—— *in Norwich:* Rigby.
(VACCINE): See VACCINATION.

INSANITY
Medical Jurisprudence of: Cooper (Haslam).
See LUNATIC ASYLUMS.
(PUERPERAL): See MANIA (Puerperal).
INSTRUMENTS
(OBSTETRIC): Osiander, Pugh.
—— *abuse of:* Nihell.
—— See FORCEPS, VECTIS.
INTESTINES
Diseases of
—— *of Children:* Dunglison.
INTRODUCTORY LECTURES: Byrne.

JOINTS
Diseases: Brodie (vol 2).
White swelling of: Bell (B.).
See KNEE-JOINT.
JOURNALS: SEE AT END OF CATALOGUE [in Lists of Donations].
JURISPRUDENCE (MEDICAL): See MEDICINE (Legal).

KNEE-JOINT
EXCISION OF: Keith (W.).

LABOUR: See PARTURITION.
LARYNGISMUS STRIDULUS OF INFANTS: Ley (H.), Reid (J.).
See CROUP.
LARYNGOSCOPE
Description and Application: Gibb.
LEGS
Ulcers of: Underwood.
LEUCORRHŒA: Jewel, Smith (Tyler), Waller (C.), Whitehead.
LIFE
(ORGANIC)
—— *Laws of:* Darwin.
LIGHTNING
Death by: Brodie (vol. 1).
LITHOTOMY: Hildanus.
Lateral operation: Gellowly.
LITHOTRITY: Brodie (vol. 2).
LIVER
Functional Diseases
—— *with Uterine Derangement:* Lane (B.).

LOGIC (MEDICAL): Œsterlen.
LUNATIC ASYLUMS
—— *Abington Abbey, Northampton:* Prichard (Cases).
—— *Brislington House, Bristol:* Fox (F. and C.).
LYMPHATICS: Hewson.

MALFORMATIONS: See DEFORMITIES, MONSTERS.
MALPRACTICE: Channing (Elwell).
MAN
Natural History of: Lawrence.
MANIA
(PUERPERAL): Gooch (R.), Reid (J.).
MARRIAGE
Physiological and Physical Relations of: Dawson.
INTERMARRIAGE *of Relations:* Steinau.
MEASLES: Armstrong (J.), Fuller (T.), Rhazes.
MECONIUM
Membrana Meconii of Fœtus: Ridge (B.).
MEDICINE
Method of Induction in: Ferguson (R.).
Introductory Lectures: Byrne.
History: Cabanis.
—— *among the Ancients:* Paulus Ægineta (Adams).
Dictionaries: See DICTIONARIES.
Principles: Billing, Cullen, Riverius.
Practice: Cullen, Riverius, Shaw (P.), Spillan, Thomas (R.), 'Lectures.'
Essays and Observations: Blasius, Blundell, Ferriar, Gooch (B.), Stalpartius, Channing.
Collected Works of Authors on Medicine: Aretæus, Harvey, Hildanus, Paulus Ægineta, Riverius, Sydenham.
Medical Reports, Cases, &c.: Bardsley.
(LEGAL OR FORENSIC): Beck, Cooper (T.), (Farr, Dease, Male), Lecieux, &c., Taylor (A. S.).
—— *Malpractice:* Channing (on Elwell).
—— See CORONER'S INQUESTS, MIDWIFERY (Medical Jurisprudence of).
(OBSTETRIC): See MIDWIFERY, WOMEN (Diseases of).
MEDICAL PROFESSION
—— *Education, &c.:* Channing (vol. 5).
MEMBRANE (MUCOUS)
—— *of the Uterus:* Duncan (J. M.).

MEMOIRS
Holme (Edw.), by W. C. Henry.

MENSTRUATION: Freind, Power, Themmen.
Influence of the Ovaries on: Négrier, Themmen.
Precocity of: Reuter (K. F.).
Diseases of: Granville, Tilt, Whitehead.
—— *Difficult Menstruation, or Dysmenorrhœa:* Rigby, junr.
—— *Nature of Membrane expelled in:* Simpson.

MERCURY
Use of
—— *in Syphilis:* Carmichael.

MESENTERY
Mesenteric Atrophy, or Marasmus: Pearce.

METRITIS
(Chronic): Scanzoni.

MICROSCOPE
Application to Clinical Medicine: Beale.

MIDWIFERY
History of its progress and improvements: Chapman, Jones (G.), Leake, Levret.
—— *in Paris*, 1770: Tolver.
—— *in* 1842—46: West (C.).
in 1862: Spiegelberg.
Principles and Practice: Arneth, Astruc, Baudelocque, Boër, Boivin, Bracken, Burke, Burns, Burton, Campbell (W.), Capuron, Churchill, Clay (C.), Collins (R.), Conquest, Craig, Daventer, Davis (D.), Dease (W.), Denman (T.), Deventer, Dewees, Dionis, Du Coudray, Dugès, Feist, Foster, Froriep, Guillimeau, Hamilton (A.), Hodge, Johnson (R. W.), Johnston (G.), Kilian (H. F.), Lachapelle, Lamôtte, Levret, Maubray, Meigs, Moore (W.), Naegele (F. C.), Naegele (H. F.), Nihell, Nisbet, Osborn, Osiander, Ould, Peu, Playfair, Portal, Power, Ramsbotham (F. H.), Raynalde, Rigby, junr., Roederer, Ryan, Saxtorph, Schmidtmüller, Schultze, Severn, Sinclair and Johnston, Smellie, Spence, Stark, Velpeau.
—— See also PARTURITION.
—— PLATES: Denman, Hamilton (J.), Martin (E.), Smellie.
—— *Manual for Midwives:* Churchill.
—— *Use of Bleeding and Opium in:* Bremner.
—— *Presentation of Dead Children:* Duncan (J. M.).
—— *Obstetric Aphorisms:* Clay (Hippocrates).

MIDWIFERY—*continued.*

Essays and Observations: Barlow (J.), Dease (W.), Hamilton (J.), Hayn, Leake, Montgomery, Radford, Ramsbotham (J.), Sommer.

Lectures in MS., &c.: Hamilton (A.), Leake, Lowder, M'Kenzie, Meigs, 'Midwifery,' Parry, Rigby, junr.

Obstetric Auscultation: See AUSCULTATION (Obstetric).

Obstetric Exploration: Hohl (A. F.).

(CLINICAL): Nisbet (W.), Simpson.

(OPERATIVE): Churchill, Clay (C.), Kilian, Pugh, Playfair (W. S.), Radford.

—— See INSTRUMENTS, FORCEPS.

—— See TURNING.

CASES *and Statistical Reports of* LYING-IN HOSPITALS, &c.: Ashwell, Barlow (J.), Collins, Collins (Clarke), Crosse, Davis (Hall), Franque, Giffard, Granville, Hamilton (J.), Ingleby, Morley (Deventer), Perfect, Reid (J.), Rigby, senr., Sinclair and Johnston, Smellie.

—— *Lying-in Institutions of London:* Levy.

—— *Queen Charlotte's Lying-in Hospital:* Brodie (G. B.).

—— *Guy's Hospital Lying-in Charity:* Lever.

—— *St. Giles's Infirmary:* Reid (J.).

—— *University College Hospital:* Murphy (E. W.).

—— *Westminster General Dispensary:* Granville.

—— *Edinburgh General Lying-in Hospital:* Hamilton (James).

—— *Dublin Lying-in Hospital:* Collins, Sinclair and Johnston.

—— *Dublin Lying-in Institutions:* Levy.

—— *Montreal University Lying-in Hospital:* Hall (A.).

—— *Christiania Lying-in Institution:* Faye.

—— *Halle Obstetrical Clinique:* Meier.

—— *Scuolo di Ostetricia, Milano:* Casati, Lazzati.

—— *Zurich Lying-in Institution:* Breslau.

MEDICAL JURISPRUDENCE OF:

—— *Question of Life or Death in Parturition [Cæsarean Section or Craniotomy]:* Levy, Naegele (F. C.).

MILK

Comparison of Human and Animal: Baines.

See INFANTS (Suckling of).

MINERAL WATERS

Thetford Chalybeate: Accum.

of Szliacs and Csiz, in Hungary: Hasenfeld.

MINERAL WATERS—*continued.*
(*Sulphureous*)
—— *in Chronic Diseases:* Armstrong (J.).
MONSTERS AND MONSTROSITIES: Harrison (J. B.), Gusserow.
(Triple): Blasius.
MOON
Influence on the Human Body: Mead (R.).
—— *in Fevers:* Balfour (F.).
MORTALITY
of Children: Roberton, Routh.
—— *relative in different diseases:* Watt (R.).
MORTIFICATION.
from Local Injury: White (C.).
MOTION
(MUSCULAR): Baglivus.
MURDER
of Infants: See INFANTICIDE.
MURMURS
Functional and Organic: Ormerod.
MUSCLES
Varieties in the system of: M'Whinnie.
Diseases, &c.: Rokitansky (vol. 3).
(VOLUNTARY)
—— *action of:* Mackall.
MUSEUMS
Catalogues of: Montgomery.

NECK
Surgical Diseases of: Ottley.
See FISTULÆ (Cervical).
NERVES: Kirkland (T.).
Functions of Nervous System: Unzer (Prochaska).
Sympathy of: Kirkland (T.).
Influence on the Muscles: Brodie (vol 2).
of the Heart: Lee (R.).
Pneumogastric [Par Vagum]: Ley, Brodie (vol. 2).
Sympathetic
—— *connection with cerebral Nerves:* Hirzel.
of the Uterus: Lee (R.).
Pathology and Diseases: Ley, Reid (J.), Brodie (vol. 3), Rokitansky (vol. 3), Romberg.
—— *connected with Pregnancy:* Lever.
—— *Irritability:* Kirkland (T.)

NOMA: Kunhardt.
NOSE
See POLYPI OF.
NUISANCES
Law relative to: Cooper (T.).
NURSING: Armstrong (G.).
Wet-Nurses
—— *Practice of hiring, its hygienic and moral effects:* Baines.
See INFANTS (Suckling of).
NUTRITION
(*Defective*): Smee (A.).
NYMPHOMANIA: Bienville.

OBSTETRIC MEDICINE: See MIDWIFERY, PARTURITION, WOMEN, &c.
ŒDEMA: Ayre.
OIL: See CROTON OIL.
OS UTERI: See UTERUS (Os uteri).
OVARIA
Anatomy and Physiology: Graaf, Négrier.
Influence on Menstruation: Négrier, Themmen.
Diseases and Dropsy: Ayre, Brown (Baker), Chereau, Montgomery, West, Channing.
—— *Colloid Cancer:* Virchow.
—— *Inflammation:* Tilt.
OVARIOTOMY: Bird (F.), Clay (J.), Southam, Breslau.
OVUM: Flourens, Jones (T. W.).
Premature Expulsion of: Power.
Spontaneous ovulation: Bischoff.

PARASITES
—— (ANIMAL): Küchenmeister.
—— (VEGETABLE): Küchenmeister.
See WORMS.
PARTURITION: Bland (R.), Boër, Clarke (J.), Clay (Harvey), Clay (Naegele), Denman, Harvey (W.), Merriman, Murphy (E. W.), Naegele (F. C.), Naegele (H. F.), Osiander, Raynalde, Schmidtmüller, Tolver, White (C.), Wigand.
Management of 1st and 2nd stages: Murphy.

PARTURITION—*continued.*
Mechanism of: Naegele (F. C.), Naegele (H. F.), Tolver.
(COMPARATIVE): Bland (R.).
Presentations in: See MIDWIFERY.
(*Premature*): Ashwell, Lazzati.
(*Protracted*): Craig.
(*Abnormal and difficult*): Clausius, Davis (Hall), Denman, La Motte, Levret, Merriman, Michell (W.), Murphy, Osborn (W.), Watts (G.).
—— *from exostosis:* Haber.
—— *sex of child as a cause of difficulty in:* Simpson.
Diseases of: Churchill, Schmidtmüller.
—— *Febrile:* See PUERPERAL FEVER.
Swelling of Lower Extremities in: See PHLEGMASIA DOLENS:
See MIDWIFERY.
PATHOLOGY
Essays, &c.: Blundell, Brodie (vol. 3).
(*Obstetrical*): Faye.
(*Surgical*): Cloquet.
PELVIMETER: Meier.
PELVIS
Anatomy: Litzmann.
—— (*Male*):
—— *Plates:* Lewis (G.).
—— (*Female*): Hull (J.), Savage (H.), West.
—— *Plates:* Lewis (G.), Savage (H.).
—— *Pelvic organs:* Savage (H.).
—— *of Mammalia:* Clay, Fischer.
Pathological Anatomy: Camper.
Inflammation: Lever.
DEFORMITIES AND CONTRACTIONS: Litzmann, Naegele (F. C.).
—— *hindering Labour:* Radford.
—— *from Osteomalacia:* Spengel.
—— *Oblique Contractions:* Clay, Naegele (F. C.), Graf (O.).
—— *on Turning in:* Wilson (J. G.).
See TUMOURS, SPONDYLOLISTHESIS.
PERINÆUM
—— *Laceration during Labour:* Cockle, Duparque.
—— *on Preserving in Labour:* Harvie (J.).
—— *on Supporting in Labour:* Hewitt (G.).
PERITONITIS
(*Puerperal*): Hull, Roche.
in fœtus in Utero: Simpson

PERITYPHLITIS: Wilhelmi.
PHARMACY: Paris (J. A.).
PHARYNX
See POLYPI OF.
PHLEGMASIA DOLENS: Hull, White (C.).
PHTHISIS, *or Pulmonary Consumption:* Armstrong (J.), Louis (P. C. A.), Sydenhami opera.
PHYSICIANS
Conduct and Duties of: Simpson.
PHYSIOLOGY
Systems of: 'Anatomy,' Bostock, Carpenter (W. B.), Gordon (J.), Lawrence (W.), Magendie (F.), Unzer (J. A.).
Essays, &c.: Blundell, Brodie (vol. 2).
Progress of, 1844-5: Paget.
PILES. See HÆMORRHOIDS.
PLACENTA
Structure and Physiology: Lee (R.), Ridge (B.).
—— *connexion with Uterus:* Lee (R.).
Management and Delivery of: Burns, Harvie (J.).
—— *Placenta Prævia:* Barnes, Read (W.), Simpson
—— *Retention of:* Naegele (F. C.), Power.
Diseased States
—— *as influencing Parturition:* Bremner.
PLAGUE: Bancroft.
PLEURISY: Huxham.
PLYMOUTH
—— *Climate:* Huxham.
Epidemics, 1728-37: Huxham.
PNEUMONIA and PERIPNEUMONIA: Huxham.
of children among Poor of London: West.
POISONS: Mead.
Poisoning by Croton Oil: Keith (G. S.).
POLYPI
of the Uterus: Gensoul, Levret, Oldham, Sarell, Simpson, Channing.
—— *Ligature of:* Goertz.
—— *Excision of:* Sarell.
(FIBROUS)
—— *of the Nose and Pharynx:* Gautier, Levret.
POST-MORTEM EXAMINATIONS: Lecieux.
PREGNANCY
Signs and Diagnosis of: Hewitt (G.), Kennedy (E.), Montgomery (W. F.), Routh (C. H. F.), Tanner (T. H.).

PREGNANCY—*continued.*
—— *Doubtful Cases:* Schmitt.
—— *Diagnosis of Twin Pregnancy:* Küneke.
—— See AUSCULTATION (Obstetric).
Management of: Boër, Clarke (J.), Merriman, Osiander, White (C.).
Duration and Term of: Clay (C.), Montgomery.
—— (*Protracted*): Clay (C.), Clay (Newnham), Craig, Louis (A.), Petit (A.).
Hygienic Effects of: Grenser.
Diseases of: Ashwell, Churchill, Guillimeau, Leake, Manning, Mauriceau, Schmidtmüller, Tanner.
— — *Corpulency during:* Chambers (T. K.).
—— *Injury to Abdomen during:* Naegele.
(EXTRA-UTERINE): King (J.), Sohege, Wagstaffe.
—— *in Fallopian Tubes:* Glover.

PRESCRIPTIONS (MEDICAL): Spillan.

PRESENTATIONS: See MIDWIFERY.

PRISM
Application of Prismatic Reflection to Investigation of Diseases in Open Cavities of the Body: Warden.

PSYCHOLOGY: Brodie (vol. 1).
(MEDICAL): Feuchtersleben.
—— See INSANITY.

PUERPERAL DISEASES: Ashwell, Guillimeau, Manning, Mauriceau, Schmidtmüller.

PUERPERAL FEVER: Armstrong (J.), Butter, Churchill (F.), Clarke (J.), Denman, Ferguson (R.), Hannay, Hey (W.), Hulme (N.), Kirkland (T.), Leake (J.), Semmelweis, Walsh.
Epidemic in Derbyshire: Butter.
—— *at Aberdeen*, 1789-92: Campbell (Gordon).
—— *at Edinburgh*, 1821-22: Campbell (W.).
—— *at Heidelberg*, 1845: Kruger.

PUERPERAL CONVULSIONS: See CONVULSIONS (Puerperal).

PUERPERAL MANIA: See MANIA (Puerperal).

PUERPERAL PERITONITIS: See PERITONITIS.

PULSE
Importance of, in relation to Chloroform: Dyce.

QUACKERY: Brodie (vol. 1).

RABIES CANINA: Bardsley, Ferriar's 'Med. Histories.'
RACHITIS: See RICKETS.
RECTUM
STRICTURE OF: Salmon.
REGIMEN: See DIET.
RESPIRATION
ORGANS OF
—— *Pathological Anatomy:* Hasse, Rokitansky (vol. 4).
RETE VASCULARE
of the fœtus: Ridge (B.).
REVULSION AND DERIVATION
Ancient doctrine of: Watts.
RHEUMATISM: Macleod.
Disease of Heart and Brain from: Macleod.
of Uterus: See UTERUS.
RICKETS (*Infantile*): Smith (J. R.), Sonntag, Weatherhead.
(*Adult*): Weatherhead.
RUBEOLA: See MEASLES.

SCARLET FEVER: Armstrong (J.), Blackburne, Brown (I. B.).
SCROFULA
Scrofulous Tumours: Underwood.
SECUNDINES
Retention of: Naegele (F. C.).
See PLACENTA.
SEX
of Child as a cause of difficulty in Parturition: Simpson.
SIPHON
Use in Anatomy: Graaf.
SKIN
Diseases: Bateman, Rayer, Turner (D.).
—— (*Intra-Uterine*): Keiller.
—— *Remedies*
—— *Local:* Turner (D.).
—— *Use of Animal Heat in eruption of:* Rigby.
Dropsy of: See ANASARCA, ŒDEMA.
SMALL POX: Fuller, Huxham, Lobb, Rhazes, Sydenham (opera).
Plans to exterminate: Haygarth.
—— See INOCULATION (Variolous), VACCINATION.

SPASMS (CONVULSIVE): White (C.).
SPECULUM UTERI: Lee (R.).
SPERMATORRHŒA: Dawson.
SPONDYLOLISTHESIS *of the Pelvis:* Billeter.
STERILITY: Smith (J. R.), Tilt, Whitehead.
STOMACH
Diseases of
—— *in Children:* Dunglison.
STRANGULATION: Brodie (vol. 1).
STRICTURE
of Rectum: See RECTUM.
SUCKLING: See INFANTS.
SUGAR
Chemistry of: Rigby, sen.
SULPHUR: See MINERAL WATERS.
SUN
Influence on the Body: Mead.
—— *in Fevers:* Balfour (F.).
SURGERY
Systems of: Bell (B.), Cooper (S.), Fergusson, Heister, Liston, Velpeau.
Collected Works: Brodie.
Surgical Essays, Cases, &c.: Barlow (J.), Bromfeild, Druitt, Gooch (B.), Stalpartius, Wilmer.
(*Clinical*): Dupuytren.
(*Conservative*): Beaney.
Minor Surgery: Bourgery.
Surgical Operations
—— See ANÆSTHETICS, ETHER.
(OBSTETRIC): See MIDWIFERY.
SYMPHYSIS PUBIS
Section of: Michell (J. P.), Osborn (W.), Vaughan (J.).
SYPHILIS: Boeck, Carmichael, Harris (W.), Sydenham.
Statistical Tables: Boeck.
Use of Mercury in: Carmichael.
—— *Nitrous Acid in:* Ferriar's Med. Histories.
SYPHILISATION: Boeck, Faye.

TEETH
Dentition and coincident disorders: Ashburner, Jacobi (A.), Mortimer.
Diseases from retention of decayed teeth: Clendon.
Artificial: Mortimer.

TEMPERATURE
of Infants in health and disease: Roger (H.).
TESTICLES
Anatomy: Warner.
Diseases: Warner.
THROAT
Diseases of: Gibb.
Putrid or Malignant Sore Throat: Huxham.
THYMUS GLAND
Physiology of: Simon (J.).
TOBACCO: Brodie (vol. 1).
TONGUE
Cancer of: Keith (W.).
TRACHEA
Diseases of: Gibb.
TRACHEOTOMY
in Croup: Schaible.
TRANSACTIONS OF SOCIETIES: See AT END OF CATALOGUE [in List of Donations].
TRANSFUSION OF BLOOD: Ashwell (Blundell).
TRANSMISSION OF DISEASES: See HEREDITARY DISEASES.
TRIALS: Morley *v.* Maddox.
TUBERCLES: Lombard.
See PHTHISIS.
TUMOURS:
Formation of: Home (Sir E.).
of Uterus: Ashwell, Lee (T. S.).
—— *Fibrous:* Routh.
of Pelvis: Tilt.
—— *obstructing Parturition:* Lever, Puchelt.
of Generative organs.
—— *Female external:* Naegele (F. C.).
(CANCEROUS): Home (Sir E.).
(SCROFULOUS): Underwood.
TUNICA VAGINALIS: See HYDROCELE.
TURNING *in Midwifery:* Radford, West, Wilson (J. G.).
—— *as substitute for Craniotomy:* Wilson (J. G.).
—— *combined external and internal:* Hicks (J. B.).
TWINS and MULTIPLE BIRTHS
—— *Diagnosis of Twin Pregnancy:* Küneke.
TYPHOID FEVER: Bartlett (E.).
TYPHUS FEVER: Bancroft, Bartlett (E.).

ULCERS: Bell (B.).
of the Legs: Underwood.
of Os Uteri: West.

UMBILICUS
Funis Umbilicalis.
—— *circumvolutions of, fatal to life:* Mayer.

UNICORN: Stalpartius.

URETHRA
(*Female.*)
—— *Diseases:* Channing.

URINARY ORGANS
Diseases: Brodie (vol. 2).

UTERUS
Anatomy and Physiology: Ridge (B.).
—— (*unimpregnated*): Waller (C.).
—— (*Gravid*): Burns (J.), Hunter (W.), Priestley.
—— *Plates:* Hunter (W.).
—— *Ganglia and Nerves*: Lee (R.).
—— *Membranes and Humours:* Harvey's Works.
—— *Mucous Membrane:* Duncan (J. M.).
—— *Relaxation of Tissue:* Montgomery.
—— *Internal surface after delivery:* Duncan (J. M.).
—— *Influence of Galvanism on its action in Labour:* Simpson.
Pathology
—— *Present state of:* Bennet (J. H.).
Diseases: Ashwell, Boivin, Hildanus, Simpson, Tilt, West.
—— *of Unimpregnated:* Waller (C.).
—— (*Organic*): Balbirnie.
—— *connected with Derangement of Assimilating Functions:* Rigby, jun.
—— *in relation to Constitutional Disorders:* Mackenzie (F. W.).
Particular Abnormal Conditions and Diseases
—— *Contraction* (*irregular*): Channing.
—— *Displacements*
—— *oblique position:* Tiedemann.
—— See below (Inversion, Retroversion, &c.).
—— *Double Uterus:* Faye.
—— *Dropsy:* Geil.
—— *Extirpation:* Newnham.
—— *Hæmorrhage:* See HÆMORRHAGE (Uterine).
—— *Inflammation:* Moxey.
—— *Chronic:* Scanzoni.
—— *Inversion:* Barker (T. H.), Newnham, Radford

UTERUS—*continued.*
—— *Irritation:* Addison.
—— *Laceration:* Duparque, M'Keever, Scott (P. N.).
—— *Loss, after Delivery:* Cooke (J. C.).
—— *Polypi:* See POLYPI.
—— *Prolapsus:* Wagner (D.), Gusserow.
—— *Retroversion:* King (J.), Simpson.
—— *Rheumatism:* Gautier.
—— *Rupture:* Clay (Crantz), Douglas (A.), Duparque.
—— *Tumours:* Ashwell, Lee (T. S.).
—— (*Fibrous*): Routh.
CERVIX UTERI
—— *Functions:* Négrier.
—— *Diseases:* Ellis (R.), Meigs.
—— *Inflammation, Ulceration, and Induration:* Bennet (J. H.).
—— *Excision for Cancer:* Simpson.
—— *Tumours:* Wagner (D.).
OS UTERI
—— *Artificial Dilatation during Labour:* Collins.
—— *Diseases:* Kennedy (E.).
—— *Cauliflower Excrescence:* Simpson.
—— *Hypertrophy:* Kennedy (E.), Wagner (D.).
—— *Rigidity and Closure:* Lever, Naegele (H. F.).
—— *Ulceration:* West.

VACCINATION: Bell (G.), Bruce, Jenner, Merriman, Moore (J.), Wilkie, Willan.

VAGINA
Atresia of: Janson.
Fistulæ: See FISTULÆ (Vaginal).
Laceration: Duparque, Goldson, M'Keever.

VARIOLA: See SMALL POX.

VARIOLA VACCINIA: See VACCINATION.

VECTIS (OBSTETRIC): Mulder.
See FORCEPS, INSTRUMENTS (Obstetric).

VENA PORTA
Anatomy of the system of: Willis (R.).

VENEREAL DISEASE. See SYPHILIS.

VENTILATION: Reid (D. B.), Braun (C.).

VERNIX CASEOSA *of Fœtus:* Buck.

VERSION: See TURNING.

VIABILITY *of Fœtus:* Campbell (A. D.).

VICTORIA (Colony of)
Progress, Resources, &c.: Archer, 'Victoria.'

VISCERA
(ABDOMINAL).
—— *Pathological Anatomy:* Rokitansky, (vol. 2).
—— *Transposition of:* Campbell (W.).

VISION
Mechanism of: Gensoul.

VULVA
Follicular Disease of: Oldham (H.).

WATER SUPPLY
of the Metropolis: Clark (T.).

WHITE SWELLING *of Joints:* Bell (B.).

WINDPIPE: See TRACHEA.

WOMB: See UTERUS.

WOMEN
History from earliest Antiquity: Alexander.
Female Economy and Constitution: Power.
—— *Variations of fertility and fecundity according to age:* Duncan (J.M.).
Hygiène: Colombat.
see MIDWIFERY, PREGNANCY, PARTURITION, UTERUS, &c.
Diseases: Addison (T.), Ashwell, Astruc, Burns, Campbell (W.), Castro (R. à), Churchill (Fleetwood), Clarke (Sir C. M.), Colombat, Davis (D.), Dease (W.), Dewees, Ferguson (R.), Gooch (R.), "Gynæciorum," Hamilton (A.), Hewitt (G.), Ingleby, Manning, Maubray, Mauriceau, Naegele (F.C.), Rigby, jun., West.
—— *Plates:* Martin (E.).
—— *Lectures on, in MS.:* Parry, Rigby, jun.
—— *Constitutional treatment:* Rigby, jun.
—— (*Surgical*): Brown (I. B.).
—— *connected with Uterine Irritation:* Addison (T.).
—— *attended by discharges:* Clarke (Sir C. M.).
—— *in India:* Shortt.

WORMS
(INTESTINAL): Rhind, Küchenmeister, Siebold.
—— *Cystic:* Siebold.
—— *Tape:* Siebold.

YELLOW FEVER: Bancroft, Bartlett.

ZOOLOGY: Lawrence (W.).
ZOONOMIA, *or Laws of Organic Life:* Darwin.

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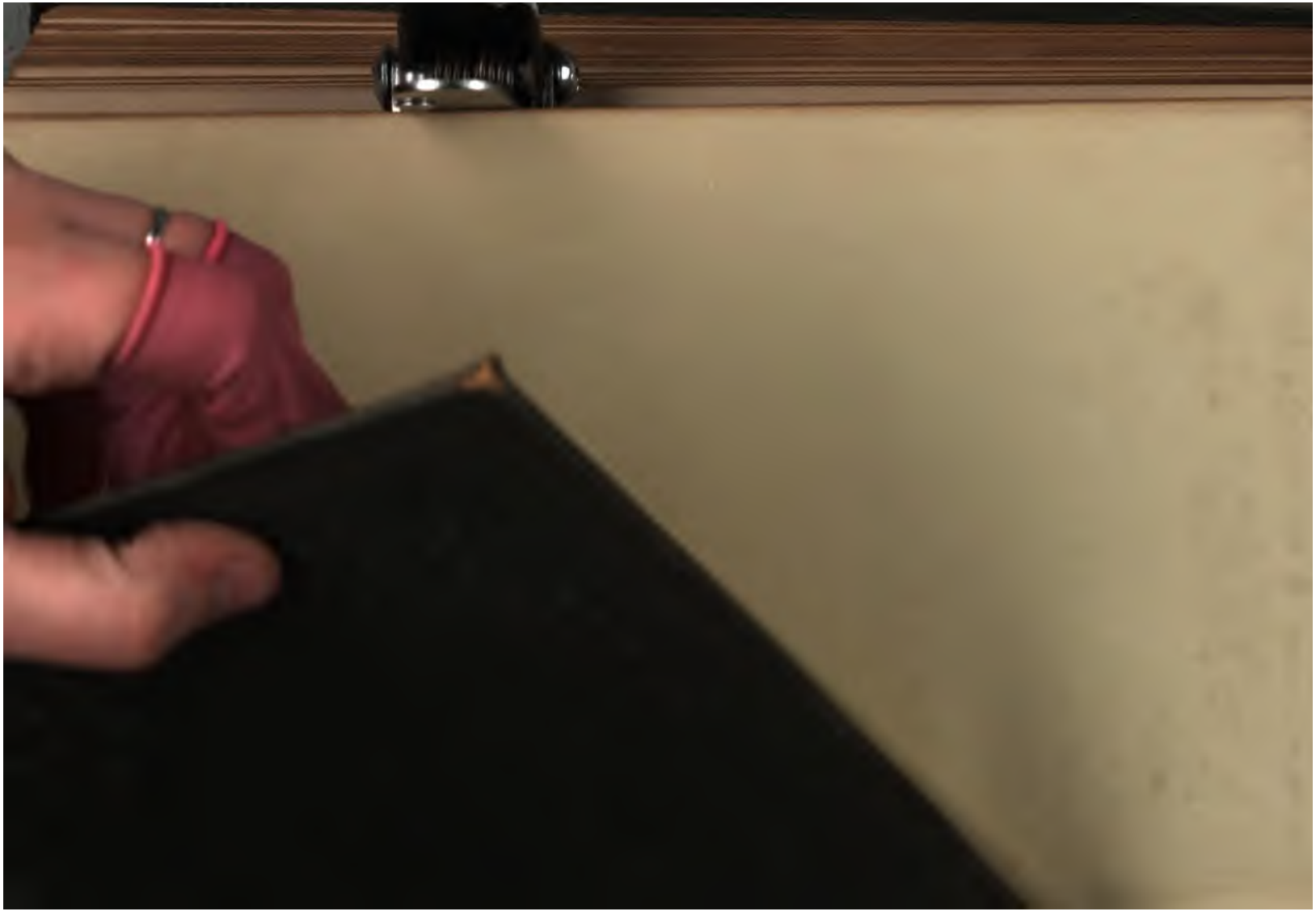
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